AN ASSESSMENT OF THE CAPACITY OF FACILITY-BASED YOUTH FRIENDLY REPRODUCTIVE HEALTH SERVICES TO PROMOTE SEXUAL AND REPRODUCTIVE HEALTH AMONG UNMARRIED ADOLESCENTS: EVIDENCE FROM RURAL MALAWI

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"The world has begun to recognize that the HIV pandemic (and other sexuality-related health problems[i]) cannot be confronted simply by applying a disease-based, biomedical, technological model of intervention; a new model must be applied that addresses sexuality, sexual rights and gender power relations" (The Ford Foundation 2005:17)

[i] Words in brackets are my own inclusion

Abstract

Despite the recognition of the influence of cultural norms on adolescent sexual behaviours in most societies (Kaler 2004; Chege 2005), less attention has been paid to the link between social norms and effectiveness of health facilities to promote adolescent sexual and reproductive health (ASRH). This thesis therefore examines the capacity of facility-based youth-friendly reproductive health services (YFRHS) to promote ASRH in rural Malawian societies where culture strongly influences adolescent sexual behaviours.

The study employs a social constructionist epistemology and a social interactionism theory to understand the capacity of YFRHS in ASRH promotion in rural Malawi. Qualitative and quantitative data were collected using a sequential exploratory design. Semi-structured in-depth interviews, participant observations, client exit interviews, survey, focus group discussions and review of health strategic and service utilisation documents/records were conducted. The results were generated by triangulating both qualitative and quantitative data.

The findings of the study illuminate how social norms related to social identities influence adolescent sexual behaviours and ASRH promotion. An exploration of the cultural context reveals a major disjuncture between an ideal norm - no premarital sex - and a modelled norm where unmarried adolescents are expected to engage in unsafe sex. It also shows the conflicts between the cultural and scientific models of ASRH promotion. Structural gender asymmetry that emphasises subservience in females and hegemonic masculinity also reduces adolescents' rights and agency in SRH promotion. The health providers are cultural agents. They manage diverse roles both as 'moral guardians' and as 'health promoters' in a way that limits their effectiveness as health promoters.

The thesis concludes that the way facility-based YFRHS is implemented has limited impact on SRH promotion among unmarried adolescents of rural Malawi. The study recommends that appropriate health promotion interventions based on conscientisation-oriented empowerment theories directed at adolescents, community and health workers should be used in ASRH promotion in societies with strong cultural influence on sexual behaviours.

Declaration

I hereby declare that this submission is my own work and that, to the best of my knowledge, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the award of any other degree of the university or other institute of higher learning, except where due acknowledgement has been made in the text.

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Dedication

This thesis is dedicated to my late grandma, Janet Chibwana who has been my torch bearer for my academic ambitions. Her advice was inspirational and a 'push' in time of academic hopelessness

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Acronyms and Abbreviations

ADF	African Development Fund
AED	Academy for Education Development
AIDS	Acquired Immune Deficiency Syndrome
ARH	Adolescent Reproductive Health
ASRH	Adolescent Sexual and Reproductive Health
β	beta
BCC	Behaviour Change and Communication
BFHI	Baby Friendly Hospital Initiative
CPDA	Centre for Development and Population Activities
CRH	Centre for Reproductive Health
CSR	Centre for Social Research
CSW	Commission on the Status of Women
CYHV	Community Youth Health Volunteer
DALY	Disability-adjusted life year
DEC	District Executive Committee
df	Degree of freedom
EA	Enumeration Area
FFS	Family Fertility Survey
FHI	Family Health International
FGD	Focus Group Discussion
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
ICRW	International Centre for Research on Women
IEC	Information, Education and Communication
ILO	International Labour Organisation
INT	Intervention
IPPF	International Planned Parenthood Federation
HMIS	Health Management Information System
MDH	Mangochi District Hospital
MDHS	Malawi Demographic Health Survey
MHRC	Malawi Human Rights Commission
MoE:	Ministry of Education
MoESC	Ministry of Education, Science and Culture
MoEST:	Ministry of Education, Science and Technology
MoH:	Ministry of Health
MoHP:	Ministry of Health and Population
NAC	National AIDS Commission
NACP	National AIDS Control Programme
NFPCM	National Family Planning Council of Malawi
NGO	Non Governmental Organisation
NnN	Nchanda ni Nchanda pa Umi Wambone (Youth to Youth for Healthy Life)
NON	Non-intervention
NSO	National Statistics Office
NRC/IOM	National Research Council/Institute of Medicine

p	Probability value
PATH	Programme for Appropriate Technology in Health
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission of HIV
PMU	Project Management Unit
PRB	Population Reference Bureau
PSRPs	Poverty Reduction Strategy Papers
QMU	Queen Margaret University
RA	Research Assistant
RHU	Reproductive Health Unit
SADC	Southern Africa Development Community
SC/US	Save the Children (US)
SD	Standard Deviation
SE	Standard error
SPHC	Selective Primary Health Care
SPU	Strategic Planning Unit
SRH	Sexual and Reproductive Health
SSA	Sub-Sahara Africa
STIs	Sexually Transmitted Infections
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations for Population Agency
UNICEF	United Nations Children's Fund
UN IRIN	United Nations Integrated Regional Information Network
VCT	Voluntary Counseling and Testing (of HIV/AIDS)
WHO	World Health Organisation
YAGAO	Youth Against AIDS Organisation
YCBDA	Youth Community Based Distribution Agent
YFRH	Youth Friendly Reproductive Health
YFRHS	Youth Friendly Reproductive Health Services

Glossary of Terms

Boy/girl friend: an established sexual relationship between a boy and a girl

Chilangizo: A ceremony where young people are given advice in some religious institutions.

Chinamwali: initiation rite

Chisuweni: Literally means a cousin; but used in this thesis to connote a tradition where female and male cousins are socially allowed to have sexual relationships

Chitomero: Traditional arrangement where parents from boy and girl's sides agree in advance that their children should marry each other in the future. Because of this agreement, they are allowed to have sexual intercourse.

Chitonombe: Camp guardian-A lead person who stays with initiates in the camp during initiation ceremony

Fisi or litunu: A man organised to have first sexual intercourse with a girl after commencement of menstruation or following initiation rite as symbol of maturity

Gojo or wokugwa mupapaya: A boy who does not have sexual intercourse. Usually considered as barren.

Hule: A prostitute or a whore

Jando/Msondo: *Jando* is a male initiation ceremony that involves circumcision and *Msondo* is a female initiation ceremony for Yao people

Kuchotsa fumbi or kwita mauta or kwita mesi: Sexual intercourse done soon after undergoing initiation rituals

Kukutula ngonji: a cleansing ritual where a widower has sexual intercourse with a young woman to mark social acceptance that he can marry

Litiwo: Initiation rite done to a woman/girl who is pregnant or just delivered to mark her reception into adult women community

Manganje: Local dance usually performed during initiation ceremonies

Namkungwi/Ngaliba: *Nankungwi* is a female traditional initiation counselor; *Ngaliba* is a male initiation counselor

Nchanda: Youth, traditionally means 'female youth'

Sexual intercourse: Intercourse that involves penetration of penis into the vagina only

Sexual relationships: refers to heterosexual relationships only

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Chapter One

The Context and Background of the Study

1.0 *Introduction*

Since the 1994 International Conference on Population and Development (ICPD) in Cairo, Egypt, youth friendly reproductive health services (YFRHS) have been recognised as an appropriate and effective strategy to address the sexual and reproductive health (SRH) needs of adolescents (UNFPA 2003). The concern about ASRH has grown following reports that sexual activity, early pregnancies and sexually transmitted infections (STIs) including HIV infection rates are increasing at unprecedented rates among adolescents (Hughes and McCauley 1998; UNFPA 2003; UNICEF 2007; Sandoy et al., 2007). The importance of facility-based YFRHS has long been recognised by health policy makers as manifested in an increasing number of countries including Zambia (Nare et al., 1996; Chirwa 1998), Phillipines and Bangladesh (Antunes et al., 1997; Koenig et al., 1997; Stanton et al., 1998; Coplan et al., 1999; Fitzgerald et al., 1999; Fawole et al., 1999; UNFPA 2003), Kenya and Uganda (Horizon 2001; Thomson 2003; UNFPA 2003) that have included this specialist service in their health sector. Malawi adopted the YFRHS in their SRH policy in 1994 (MoH 2002). From its outset, YFRHS focused on improving the availability, accessibility and quality of SRH services because YFRHS were developed against the backdrop of inadequacies on the part of health systems to provide SRH services in an efficient, effective and equitable manner to young people (United Nations 1995a; 1995b;WHO 1998b; 2001b; UNFPA 2003).

While most barriers to adolescents' utilisation of SRH services have been attributed to quality of SRH services (United nations 1995a; 1995b; Senderowitz 1999); a critical analysis of the barriers to ARH promotion reveals that cultural norms that influence people's behaviours and actions related to sexual and reproductive matters are also extremely important. Furthermore, the current rapid social, political and economic transformations in sub-Saharan Africa also appear to have a profound impact on the social norms affecting adolescents (Ham 2004; Blum 2007).

A review of literature shows that cultural and social norms influence adolescents to adopt unsafe sex practices in most African countries including Kenya, Malawi, Nigeria, Ethiopia and Uganda (Kiragu and Zabin 1995; Kibbe 1999; Caldwell et al., 1998; Leclerc-Madlala 2002a; 2002b; Kaler 2003; 2004; Rankin et al., 2005a; Chege 2005; Chimbiri 2002; 2007). Other evidence also shows that some health workers become judgemental or hostile to unmarried people who come for SRH services. Also some health workers and communities are reluctant to teach them about SRH (Mbugua 2007) and provide them with SRH services (Chirwa and Kudzala 2001). This is because prevailing cultural norms in some countries proscribe young, unmarried people having sex (Rogoff 1990; Chirwa and Kudzala 2001). Some health facilities in some countries also have restrictive policies (such as consent requirement to access SRH services) that hinder unmarried adolescents to access SRH services (Shelton et al., 1992; Barbieri 1993; Chirwa and Kudzala 2001; UNFPA 2003). Moreover, in most societies, the SRH needs and rights of unmarried adolescents are not acknowledged. Thus, because of culture, government policies and plans do not include policies and resource allocations that can promote implementation of SRH services targeting unmarried adolescents (Klein 1988; UNICEF 2003).. Because of the impact of cultural norms on ASRH, understanding both the way these norms influence adolescent sexual practices and the capacity of facility-based YFRHS to address such norms is essential for designing effective ASRH promotion interventions in countries throughout the world.

1.1 *Overview of Adolescent Sexual and Reproductive Health Status in Malawi*

In Malawi, as in other countries, (WHO 1998b; 1998c; UNFPA 2003; UNAIDS 2004), culturally determined sexual practices are common among unmarried adolescents (CSR 1997; Kornifield and Namate 1997; UNAIDS 2001; Munthali et al., 2004). In Malawi the situation is more complex because although premarital sex is on the one hand, not formally sanctioned, on the other, it is an intrinsic part of certain initiation rites that encourage unmarried adolescents to engage in unsafe sexual practices (Kaler 2003; 2004; Chimbiri 2002; 2007). Thus, sexual activity is common among unmarried adolescents and occurs at quite early ages sometimes before puberty (Helitzer-Allen and Makhambera 1993; Stewarts et al., 1998) with some as early as eight years or below (Maluwa-Banda 2001). Other statistics shows that some adolescents have sex as early as age ten years or

even earlier with over 50% of adolescents reporting having sexual intercourse before the age of fifteen. The majority report having sexual intercourse by the age 17 years (Helitzer-Allen and Makhambera 1993; McAuliffe and Ntata 1994; Bisika and Ntata 1997; CSR 1997; Hickey 1997; NSO and Macro ORC 2001; Kachingwe et al., 2001; Chimbiri 2002; Poulin 2006b).

Although most unmarried adolescents are sexually active, many of them do not use prevention measures for SRH problems (Save the Children UK 2000; MoEST 2002; MoESC 2000). Similar reports have also emerged from other parts of sub-Sahara Africa (Agyei and Epema 1990; 1992; Agyei et al., 1992; 1994; Gage and Meekers 1993; Campbell and Mbizvo 1994; Mbizvo et al., 1995; Buga et al., 1996; Ritcher et al., 1997; Makiwane 1998). Because of such unsafe sexual practices, most adolescents in Malawi are vulnerable to early pregnancies and STIs including HIV/AIDS (Chirwa and Kudzala 2001; UNFPA 2003; Kaler 2003; 2004).

Adolescent pregnancies are common in Malawi. Other reports indicate that about two-thirds of females 19 years or younger have a child or are pregnant with their first child (UNESCO/MIE/UNFPA 1998; NSO and Macro ORC 2001). The 2000 MDHS further reported that about one-quarter of adolescent females are already mothers with at least one child, and a further 8% are currently pregnant while about 4% of women age 15 have started childbearing (NSO and Macro ORC 2001). An IPPF report indicated that 14% of adolescent girls aged 15–19 years give live births each year (IPPF undated). Another study conducted at one major referral hospital, Queen Elizabeth Central Hospital in Blantyre, also showed that out of the 11,924 women who gave birth in 2001, 3,339 (28%) were adolescents (Tadesse 2001).

In addition, the review indicates that the age-specific fertility rate for adolescents age 15-19 is rising. For example, while the age-specific fertility rate for adolescents age 15-19 was 202 per 1,000 women in 1984 (NSO 1987) and 161 per 1,000 women in 1992 (NSO and Macro ORC 1994), the 2000 MDHS report indicates that the age-specific rate has risen to 172 per 1,000 women (NSO and Macro ORC 2001). While adolescent pregnancies are considered to a certain extent as a deviant behaviour because unmarried

adolescents are socially not expected to be sexually active and hence not to start childbearing, married adolescents who become pregnant or start childbearing are considered to be unproblematic. Society expects married couples to have children regardless of their age (Chimbiri 2007). However, early childbearing can increase adolescents' risks to health problems during pregnancy, labour or puerperium (UNFPA 2003). Moreover, early childbearing can lead to early school drop-out which can eventually reduce the adolescents' future employment prospects due to low educational qualifications attained (ibid.).

Like adolescent pregnancies, the prevalence rates of STIs among the adolescents are increasing in Malawi (MoH 2002). The 2000 MDHS report showed that the prevalence rates of curable STIs were 1% for young women and 2% for young men in the last 12 months preceding the survey. Among adolescents aged 15 – 19years, about 1% of females and 1.9% of males reported of having STIs in the 12 months preceding the MDHS (NSO and ORS Macro 2001). However, the MDHS acknowledges that these figures might be lower than the actual situation due to underreporting especially among women (ibid.), who could rarely visit clinics when they have STIs (Gunatilake 1998). Moreover, the tendency of most adolescents to seek their health care in shops, pharmacies as well as through peers could also result in low figures being registered at the hospital records upon which these estimates were based (Zachariah et al., 2002).

Although HIV prevalence is currently stable in Malawi, the HIV prevalence rates among adolescents are estimated to be higher than the national HIV prevalence rate of 14% (NAC 2003; UNFPA 2003; UNAIDS 2008b). Several reports confirm that the majority of people acquire HIV infection in their teens (UNESCO 1996; UNFPA 2003).

While statistics shows that the current adult prevalence rate is about 15%, the rate among the youth is however believed to be higher (NAC 2007, UNAIDS 2008b). Other press reports indicate that 67% of new infections are among young people aged between 15 and 24 years (The Chronicle Newspaper 2004). However the 2001 MDHS report acknowledges that figures may be underestimated due to methodological limitations such as the use of sentinel surveillance sites located in urban and semi-urban areas where

pregnant women only are tested (NSO and ORC Macro 2001; see also WHO 2001a; 2002c; UNAIDS and WHO 2003). These statistics suggest that HIV infection among adolescents is a major concern in Malawi.

The HIV prevalence rates vary by sex. While HIV infection occurs among the youth (13-24 years), the infection rate is higher amongst females than males (UNAIDS 2008b). Other reports suggest that HIV infection rates are 4-6 times more among girls than boys in the same age group (UNAIDS 2001). The Malawi Government (2004) report also indicates that HIV prevalence rates among adolescent females 15-19 years of age are estimated to be seven times greater than their male counterparts. Several studies however suggest that cultural norms might influence the HIV prevalence rates among young people (Kachingwe et al., 2001; Chimbiri 2002; Kaler 2003; 2004; Poulin 2006b). These studies reveal several cultural traditions that could increase young people's vulnerability to HIV infections. Overall, the evidence shows that culture is likely to have a profound effect on ASRH in Malawi.

1.2 *Background and Rationale of the Study*

A critical analysis of the social determinants of SRH in Malawi indicates that several factors contribute to adolescents' increased vulnerability to SRH problems and to the failure of the current ASRH promotion interventions to have impact on the social determinants of SRH among unmarried adolescents. Among others, constructions of adolescence and sexuality appear to have important implications for SRH. Therefore before introducing the study aims and objectives, this next section introduces notions of adolescence and sexuality[2].

The concept of adolescence and its existence are contested in most Malawian societies (Save the Children 2000; Munthali et al., 2004; CRH 2005). While the World Health Organisation defines adolescence referring to it in chronological age period- 10-19 years period of life (IPPF 1994; WHO 2003b; UNFPA 2003) (see also section 2.1 for details), the definition of adolescence in Malawi varies from one institution to another. While almost all societies agree on adolescence as being equal to unmarried or not commencing

[2] These themes will be developed more fully in Chapter 2

childbearing, in other tribes like Yaos, adolescence refers to unmarried boys only (Chief Mpondasi 2004, *personal communications*). Thus, among the Yao tribes, boys are considered to experience a transition from childhood to adulthoods while girls were immediately considered adults and ready to enter into marriage once menstruation commenced (see section 2.1.3 for full discussion on adolescence in Malawi). Also, those who are married or have given birth are considered as adults regardless of their ages. These variations in the conceptualisations of adolescence between the traditional and health professional stances could make the acceptance and support of modern SRH promotion interventions targeting adolescents difficult in some communities.

Like adolescence, adolescent sexuality is a strongly contested concept in almost all Malawian societies. Sexuality is not just about sex (Options for Sexual Health 2008) but rather is described as the expression of identity through gender (male/female) (LaRossa and Reitzes 1993; Chege 2005; Chimbiri 2002; 2007). Sexuality involves the process that defines and dictates the way in which people negotiate their relationships with others, and in turn, how people's sexual actions impact on them (Options for Sexual Health 2008). Often, this conceptualization of sexuality comprises a broad range of behaviours and processes that include those from psychological, social, cultural, political, ethical, moral, legal, religious or spiritual aspects which define morality in various contexts (see Montfort Press undated; Byamugisha 2000; Ham 2004; CRH 2005). These behaviours and processes influence values regarding relationships, sexual ethics, sexual culture and psychology in relation to gender and sexual role; physical factors sexual characteristics, sexual drive, sexual intercourse and sexual activities, and sexual orientation – heterosexual, homosexual and bisexual (Ng et a; 2000). Thus, sexuality involves the way sexual socialisation, knowledge, beliefs and values, religion and morals shape the way males and females behave in the society (Ford Foundation 2005; Options for Sexual Health 2008) (see section 2.2.1 for details).

By contrast, the conventional view of sex describes it as intercourse between male and female: "*When people talk about sex they think about male and female. They think about the penetration of (the) penis into vagina*" (Jaffray 2006: 4). Thus, '*penetrative sex is generally viewed as "natural" or "normal sex"'* (Richardson 1993:233). Moreover, in

most of these traditional or religious societies, particularly among Christians and Moslems, sexuality is only associated with procreation. Sex is only acceptable in marriage for the purpose of procreation only (Monfort Press undated; Phiri 1998).

Also, sexuality is seen by some adolescents as a resource which can be used to earn a living (Masanjala 2007) and therefore feel that they have the right to do whatever they can for them to survive. By contrast, religious and traditional[3] norms define premarital sexual activity as a deviant behaviour (see also Dehne and Riedner 2001). In this case, that means that any conceptualization of sexuality that differs from the norm – in the case of Malawi, heterosex within marriage - such as homosexuality and other forms of sex and sexual practices other than heterosexual intercourse is considered as abnormal and deviant.

Moreover, there are disagreements in the conceptualizations of sex among heterosexual partners. For instance, while other people particularly female participants in another study in South Africa acknowledged that sex can include other practices such as "*touching each other, kissing, massaging exciting each other by touching each other's genitals*" as well as oral sex (Jaffray 2006:4), male participants do not understand sex as anything other than sexual intercourse involving penile penetration: "*No! (Sex cannot include practices other than intercourse*) (Jaffray 2006:5). Thus, while sex practices can be understood to mean more than penile penetration even among heterosexual females, this notion is not acknowledged by some heterosexual males within one society and this disagreement can affect heterosexual partners' agency to adopt safe sex practices.

Despite the recognition of forms of sex other than penetrative sex among some heterosexual partners in the sub-Sahara region (Jaffray 2006), health promotion interventions in the region promote measures aim to reduce the risk of penetrative sex but do not promote non-penetrative sex practices. Richardson(1993:233) therefore critiques the emphasis in the public domain on ABC (abstinence, be faithful and use a condom)

> AIDS education campaigns have, by and large, uncritically accepted a view of sex as intercourse. We have the 'condom solution'. Safer sex advice is centred upon fewer sexual partners and being told 'always use a condom'… Why do we never hear about non-penetrative sex as a less risky and potentially more pleasurable way of preventing AIDS?

[3]The word "traditional" in this thesis means "local or "indigenous" or "native"

Thus, because of this heterosexist understanding of sex, promotion of measures to reduce the risk of penetrative sex remains the norm in ASRH promotion in most countries. Such health promotion approaches deny adolescents the option of choosing to practice the non-penetrative safe sex measures

Evidence from some studies in Malawi (CSR 1997; Munthali et al., 2004; CRH 2004) also suggests that culture influences the conceptualization of biological development process in terms of sexuality. In most societies particularly those that undertake *passage de rite* for young people, the ritual marks the sexual maturity of adolescents regardless of their age (CSR 1997; Munthali et al., 2004; CRH 2005). Most traditions encourage young people to initiate sexual activity and, and for girls to start childbearing (Stewarts et al., 1998; CRH 2004). This social construction of sexual maturity however contradicts the biological sexual maturity (see UNFPA 2003). Because of these variations between the biological and traditional perspectives of sexual development, modern health promotion interventions aimed to promote SRH among young people may not be accepted and supported by the community (see Kaler 2004; CRH 2005).

In Malawi there is a degree of syncretism between the teachings of the churches, the mosques and traditional practice. Some traditionalists at times promote premarital sex as *passage de rite* (Munthali et al., 2004). Furthermore, though premarital sex is formally prohibited in religious societies, marriages of young people including teenagers are acceptable in religious institutions. Thus, sexual intercourse among young married people (including those in early adolescence– 10 - 14 years) is not prohibited in religious societies. Both traditional and religious societies put males as the controllers of sexual and reproductive matters (Chege 2005; Chimbiri 2007). All of this contrasts with the perception of the majority of adolescents who view all premarital sex as a recreation which should be enjoyed by people regardless of their marital status (CSR 1997).

This latter view aligns more closely with modern or developed societies where having sex is viewed as a human right for all people regardless of the marital status though use of protective measures is also emphasised (United Nations 1995a; UNFPA 2003; WHO 2005). Thus, while modernists' views encourage safe sex practices such as contraceptive or condom use in order to promote SRH as acceptable even among unmarried people

(United Nations 1995a; 1995b; WHO 2005), the traditionalists may either prohibit or encourage premarital sex. Thus, the modernists' view considers unprotected sex as unsafe. However, the construction of some sexual behaviours as unsafe is problematic in some societies because of the differences between lay people's (social) perceptions and health professionals' perceptions of risk (Lopes 1987; Brookmeyers and Gail 1994). Thus, what may be biomedically described as unsafe and risky behaviour may be viewed differently from the social perspective. These disjunctures can be challenging in implementing biomedical interventions in societies where more traditional social norms have a particularly strong influence on people's health behaviours (see Chirwa and Kudzala 2001).

Because of the diverse concepts of adolescence and adolescent sexuality held by local and biomedical communities, some local community members may not accept or support health promotion interventions that contradict their culture. Besides, donors may not provide financial support for interventions of which they do not approve of as was the case inn the Global Gang Rule (Medical News TODAY 2009) though the rescinding of the rule by President Obama[4] provides hope of implementing such interventions. Without such rescission, lack of donor aid may result in having few or no interventions that might benefit other sector of the populations.

Besides the contestations that derive from biomedical and societal perceptions on adolescence and sexuality, socially constructed sexual norms in most Malawian societies are ambiguous in such a way that they could confuse adolescents' SRH related behaviours. 'Ambiguous norms' in this thesis refers to contradictory value systems of sexual or social norms co-existing in one society. For instance, while premarital sex is traditionally prohibited (CSR 1997; Montfort Press undated; Ham 2004), some traditions in the society encourage unmarried young people to be involved in sexual activity especially during initiation or cleansing rites (CSR 1997; Munthali et al., 2004; Kaler 2004). Additionally, though out-of-wedlock pregnancy is a taboo (Montfort Press undated; Byamugisha 2000), the importance of having children is communicated to young women from an early age before marriage, and the message is passed in such a way that

[4] President Obama rescinded George Bush's Global Gang Rule which prohibited the provision of funds to sponsor some SRH interventions like abortions (Medical News TODAY 2009).

many young women do not see pregnancy and early motherhood as a significant problem (CSR 1997; Save the Children USA 2000).

Besides, the variations in the social constructions of some SRH issues among various institutions also influence the promotion of ASRH. For instance, while the health professionals' view that SRH conditions like early pregnancy and STIs including HIV/AIDS as issues of health concerns, the same physiological or pathological states are viewed differently by other institutions in the society. For instance, some conditions like STIs are considered as a badge of masculinities while pregnancy is a sign of femininity-potency and fertility (Kaler 2004). Some traditional societies also consider HIV/AIDS as a result of failure to respect ancestral spirits (Letamo 2003) while religious people view it as a result of sins against God (Byamugisha 2000). Likewise, local institutions (both traditional and religious) consider pregnancy as a pre-ordained inevitable condition that cannot be prevented (Kaler 2004). Though premarital sex is prohibited in most societies, sexual intercourse is still used as a passage of transition to adulthood (CSR 1997; Munthali et al., 2004; CRH 2005) and adolescents' involvement in sexual activity raises social status in the society (Kaler 2003; 2004). Therefore, because of local perceptions such as these, promoting interventions that aim to prevent the occurrence of pregnancy or even treating disease may meet resistance or may not be supported. Such ambiguities mean that efforts to change what biomedical practitioners term, 'unsafe' sexual practices may be protested because of the prevalent social values associated with the behaviours.

Furthermore, because of social expectations of adolescents, access to SRH services is restricted in most societies. While the WHO's rights-based approach promotes access to SRH services as a right for all people regardless of marital status or age (WHO 2005), traditional and religious norms in Malawi view the promotion of access to SRH services by unmarried people as immoral (Montfort Press undated; Byamugisha 2000; Chirwa and Kudzala 2001; Ham 2004). In most Malawian societies, people are only expected to use SRH services once they have entered into marriages or sometimes after giving birth. In most societies people believe that giving access to SRH services to unmarried adolescents could make unmarried adolescents to be promiscuous and contravene social norms (Chirwa and Kudzala 2001). In some instances what is considered as being healthy sexual

behaviour by health professionals like condom use is considered as socially unnatural or unbiblical in some traditional or religious institutions (Byamugisha 2000; Mtika 2001; see also Setel 1999).

Additionally, although most societies teach young people about sexual and reproductive issues during initiation ceremonies, societal norms limit parents' role as sex educators of their children (Stewarts et al., 1998). Instead, traditional counsellors, locally known as '*Anankungwi*', or '*Ngaliba*', and religious groups counsel young people about sex in most Malawian societies (ibid.). This tradition however denies young people easy access to SRH information considering that parents spend most of the time with their children (Grotevant and Cooper 1986a; 1986b; Kroeger 1998; Seiffge-Krenke 2006).

Ambiguous cultural norms related to sexual behaviours among unmarried adolescents that exist within single Malawian societies are very likely to limit the empowerment of those who are currently powerless in SRH because of the lack of policies and programmes that can promote ASRH promotion initiatives. The same ambiguous culture may even disempower adolescents and other people who currently experience some degree of empowerment through education and SRH knowledge. Cultural norms and the attendant fear of stigma are likely to limit empowered young people's capacity to execute or take actions that can further promote ASRH.

Moreover, because of the influence of culture, communities may resist to change their culture in a way that can benefit ASRH (Thompson 2008). Evidence is obvious in Malawi where despite the promotion of modern healthcare by the government, use of traditional practitioners persists in most societies (Lema 1997; Phiri 1998; Zachariah et al., 2002; Hatchett et al., 2004; see also Kalichman and Simbayi 2004; Mshana et al., 2006). In some instances, Malawians like other Africans (Sebit et al., 2000; UNAIDS 2002b; Imogie et al., 2002; Kusimba et al., 2003; SADC 2003) patronize both the western medical system as well as the indigenous one, simultaneously or one after another regardless of their education level (Zachariah et al., 2002; Hatchett et al., 2004). In some cases, indigenous religious and medical practices and beliefs have been incorporated in

many African churches (Phiri 1998). All these culture related factors can have an impact on SRH promotion for unmarried adolescents.

Despite the recognition of these cultural factors and their potential impact on adolescent sexual and reproductive behaviours and ASRH promotion in Malawi (Chirwa and Kudzala 2001; Munthali et al., 2004; Kaler 2004; see also Mogensen 1997; Kusimba et al. 2003, Kalichman and Simbayi 2004)- increasing adolescents' vulnerability to SRH problems (Clever 2002; Doyal 2002; Dixon-Muller 1993a; 1993b; Grant and Logie 2005); there has been less attention paid to the links between social norms and the functioning of health facilities in the promotion of ASRH. This has been so despite the evidence that shows that the extensive behavioural change and communication (BCC) programmes aimed to improve ASRH has not been translated into adoption of safe sex practices among unmarried adolescents in Malawi (NACP and MoHP 1999; NAC and MoH 2003; Poulin 2006b). In this case, the centrality of culture in determining adolescent reproductive and sexual practices in Malawi means that there is need to question and examine critically the role of YFRHS in the promotion ASRH. Several researchers (Boubacar 1991; Resnick et al., 1994; Kirby 1999; WHO 2003b; Coombs 2000 cited in NAC and MoH 2003; Poulin 2006; see also National Research Council 1993) also argue that there is need for more programmatic attention directed to the sexual and non-sexual circumstances that lead to adolescent sexual risk-taking in order to promote ASRH in societies social forces play a great role in SRH. The knowledge from this study might therefore inform health policy makers, health managers and health promoters who have the responsibility for the design and implementation of effective ASRH interventions that target unmarried adolescents in societies where social norms strongly influence adolescents' sexual and reproductive practices (WHO 2003b; 2006a; 2006b).

1.3 ***Purpose of the Study***

The present study was designed to assess the capacity of the facility-based YFRHS to improve the SRH of unmarried adolescents through facilitating the adoption of preventive measures for pregnancy and STIs including HIV/AIDS in culturally-conservative societies of rural Malawi

The specific objectives of the study were:

1.3.1 To determine the level of adoption of safe sex practices among unmarried adolescents and examine the extent to which such adoption is associated with facility-based YFRHS in rural Malawi

1.3.2 To examine how social and cultural norms influence adolescent sexual behaviours in culturally-conservative Malawian societies

1.3.3 To determine the factors that affect the capacity of facility-based YFRHS to promote SRH among unmarried adolescents in culturally-conservative societies

1.3.4 To determine the theoretical utility and limitations of YFRHS strategy in the promotion of SRH among unmarried adolescents.

1.4 *The Study's Conceptual Framework*

This study conceptualises adolescent sexual behaviour as being learnt during socialisation through the process of social interactions. Sexuality, which influences sexual behaviours, is constructed through the interaction between individual adolescent and social structures (Ng et al., 2000). Through social interactions, social norms, values and beliefs are passed on to adolescents. In this way young peoples' social identities are formed (Steinberg and Silverberg 1986; Palmonari et al., 1989; 1990; Tarrant et al., 2001). (See section 4.2 for details on social interactionism). In turn, social identities define moral behaviour exhibited among its social group members (Turner 1986).

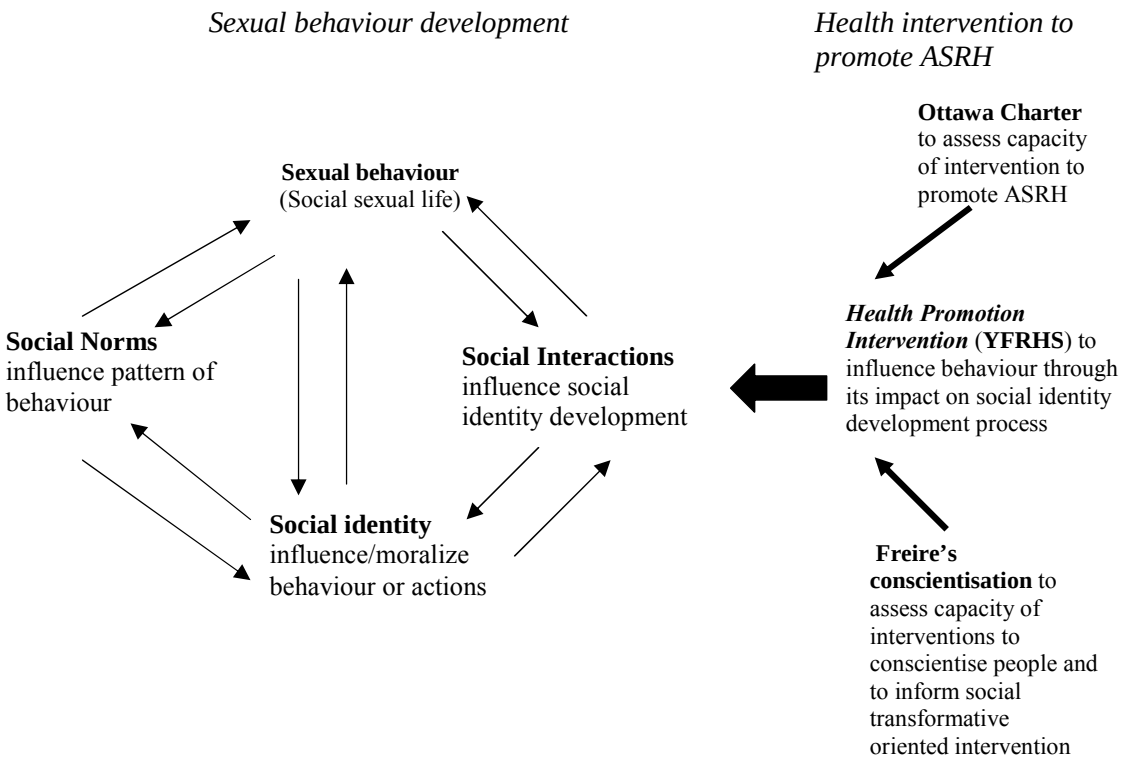
These social identities define the norms which also specify the expected sexual behaviours of the members of the social group. The expected behaviours eventually forms the norms of the social group and are incorporated into the group's social sexual lives. Adolescents follow the norms in order to maintain their social identities. Several studies indicate that adolescence is a period when importance of social identities in shaping group behaviours is very apparent (Steinberg and Silverberg 1986; Palmonari et al., 1989; 1990; Tarrant et al., 2001; Leclerc-Madlala 2002; Kaler 2004). Other studies also indicate that

adolescents are often strongly affiliated with their peer groups as compared to adults (Liebkind 1982; Gavin and Furman 1989; Cotterell 1996). Thus, the link between social interaction, social identity formation and social norms are central to adolescent sexual behaviour.

Due to the significance of social interactions and social identities on adolescent sexual behaviours, health interventions aimed to promote safe SRH practices need to have influence on the process and content (norms passed on) of social interactions/socialisation and social identity formation so that adolescents can develop healthy sexual identities that will eventually affect their behaviours.

Therefore to understand the capacity of health services to promote health in societies where social identities are influential in people's behaviours, the conceptual framework of this study draws upon social interactionism (Mead 1934) – (see section 4.2 for details); social identity theory (SIT) (Tajfel and Turner 1979; 1986), the principles underpinning the Ottawa Charter for Health Promotion (WHO 1986a; 1986b) and Freire's (1973) conscientisation theory. These theories will help to understand the processes of the influence of social identities on adolescent sexual behaviours as well as the role and capacity of facility-based YFRHS to influence ASRH behaviours- see diagrammatic presentation of the link between the theories in the figure below.

Figure 1.1: **Linking of Theories used in the Conceptual Framework**



Social identity theory (SIT) as used in this study is a group of social psychological theories that explain why individuals identify with and behave as part of social groups. who adopt shared attitudes to outsiders (Tajfel 1981; Tajfel and Turner 1986). Social identity theory is explicitly framed by a conviction that collective phenomena like social behaviour cannot be adequately explained in terms of isolated individual processes alone (Abrams 2006). Social identity theory embraces a number of interrelated concepts and sub-theories that focus on social-cognitive, motivational, social interactive and macrosocial facets of group or social life (ibid.). These may include group's specific practices and social/cultural norms, attitudes, values, beliefs, social institutions, ethnicity, culture, religions, media, peers and measures for social control of behaviours (Campbell 1995).

Social identity influences behaviours in different ways. Social identities contribute to the development of a higher level of self-concept (Mummendey et al., 1992; Branscombe and Wann 1994; Noel et al., 1995) and general feelings of self-worth (Palmonari et al., 1990;

Cotterell 1996). According to Tones and Tilford (1993), agency to carry out activities that promote health is enhanced by self-concept, particularly by a sense of self-esteem, self-confidence and self efficacy.

A sense of social identity also motivates group members to both protect and enhance that identity by engaging in behaviour which secures a positive feedback from the group members (Tarrant et al 2001). Threats to an established social identity are commonly resisted. Resistance serves therefore to both protect and reinforce identity (Branscombe and Wann 1994; Noel et al., 1995; Veruyten 1995; 1998).

In this way, social identity defines how health-related behaviours are shaped and constrained by collectively negotiated social identities (Phinney and Chavira 1992; 1995; Martinez and Dukes 1997; Campbell 2000; MacPhail and Campbell 2001; McMahon and Watts 2002). However, as social identities are constructed and reconstructed within range of structural and symbolic constraints (Turner 1986), this can in turn place limits on people's extent to control their health. Therefore, SIT is used in this study as to inform a social psychological analysis to understand how for example young people or health workers conceive of themselves and their role in society including their part in social or group processes and inter-group relations and the way that in turn influences group members' behaviours (Abrams 2006).

On the other hand, the Ottawa Charter of Health Promotion (WHO 1986a; 1986b) defines health promotion as the process of enabling individuals and communities to increase their control over the determinants of health, and thereby increase their health. Health promotion as described in the charter is centred on empowerment of the people; and can be achieved through a combination of actions by individuals, communities and governments designed to enable people to influence their lifestyles which influence their health status (ibid.).

However, because most social identities in Malawi disempower adolescents, communities and health workers to deliver ASRH activities (see Chirwa and Kudzala 2001), there is need to have a health promotion strategy that promotes social identities that empower

people to undertake ASRH activities. For instance, most gendered norms disempower both males and females in relation to ASRH (Kaler 2003; 2004). While most gendered norms appear to empower males, in fact most of them encourage them to carry our risky sexual practices (ibid.). Similarly, because stigma is used as social control in a society, the fear of stigmatization discourages adolescents, communities and health workers to carry out ASRH promoting activities (Rankin et al., 2005). In this case, health promotion should aim to empower individuals, communities and health workers to influence the process of social identity formation. In this way different stakeholders can develop critical consciousness skills that can liberate them to act independent of the influence of social norms some of which promote risky behaviours (Friere 1973; Mustakova-Possardt 1998; 2003) (see Figure 1.1).- see also section 2.3.2 for details on Ottawa Charter. Therefore, the principles of empowerment that underlie the Ottawa Charter for Health Promotion framework (WHO 1986a) is used in this study to examine the capacity of YFRHS to promote ASRH in societies where cultural norms play a great role in adolescent sexual behaviours.

Furthermore, because people's notions of their social identity is strongly and deeply rooted in society's beliefs (Freire 1973; 1998; Mustakova-Possardt 1998), Freire's (1973) conscientisation theory is then used to analyse the capacity of YFRHS to influence the development of critical consciousness about ASRH among adolescents, communities and health promoters so that they can change the norms which do not support ASRH. The Freirian theory is also used in the discussion section to inform the development of conscientisation-oriented transformative health promotion strategies - see section 7.3 for details on Freire's theory.

Based on the above conceptualisation of adolescent sexual behaviours and the role of YFRHS in ASRH promotion, this study argues that unless facility-based YFRHS have the capacity to transform the social identities that influence adolescents', communities' and health workers' attitudes towards initiatives that promote ASRH, increased availability, access and improved quality of the services alone cannot effectively contribute to the adoption of safe sex practices in societies where social norms play a particularly strong significant role in shaping adolescents' sexual behaviours.

The theories used in this conceptual framework are particularly well employed in this study as they facilitate the examination of the processes underlying adolescent group's social identity-related behaviours in societies as well providing a framework for assessing the capacity of facility-based YFRHS to empower adolescents, health workers and communities to promote ASRH.

1.5 *Significance of the Study*

Health facilities have been long considered by many governments as a prime setting for SRH promotion activity for adolescents in poor resource settings. As such, increasing interest has been paid to make health facilities youth-friendly in order to promote service utilisation among adolescents (United Nations 1995a; 1995b; Senderowitz 1997). Health care policymakers and planners are increasingly giving attention to the life phase labelled as adolescence (WHO 1998c). They recognize its special needs and respond with various adaptations and efforts to deliver YFRHS (Senderowitz et al., 2003).

Furthermore, as 85% of Malawi population live within 8-10 kilometres from a functioning health facility (Kalanje 2005; ADF 2005), these facilities are well placed to reach adolescents with health promotion activities. Health facilities represent the concentration of the scarce health service resources, professional skills and medical technology in resource poor settings (Johnson and Baum 2001). Furthermore, for the most part, health facilities are respected by communities as a source of health care. Communities see them as credible sources of advice and expertise on health issues in addition to the provision of services for the sick (Aiello et al., 1990).

Moreover, health facilities that provide SRH are already established and available in many places in Malawi and adolescents already come to health facilities for other reasons like general health care (MoH 1999a; 1999b; 1999c; 1999d).

In this thesis I demonstrate that the use of SRH services by unmarried adolescents in Malawi is currently seen as a social taboo (see also Chirwa and Kudzala 2001; Munthali et al., 2004). I further argue that strengthening the capacity of health facilities to provide accessible and appropriate YFRHS that can transform the social norms to support ARH

could ensure YFRHS play a significant role in reaching unmarried adolescents with SRH services as well as empowering the adolescents, health workers and communities for effective promotion of SRH among unmarried adolescents in rural Malawi. Thus, YFRHS, like other health services, require an effective health system that can support the delivery of services to adolescents as well as overcome barriers that undermine ASRH promotion (WHO 2003a; 2003b). Thus, it is critical that policies concerning YFRHS, their planning, implementation and management together with design and preparation of health workers are developed so as to strengthen the effectiveness of health facilities in delivery of YFRHS

Research in this area therefore, can play an essential role in identifying and drawing interventions to overcome social and cultural determinants of SRH inequalities and health-system deficiencies that stand in the way of achieving the highest attainable standard of SRH for unmarried adolescents. In this way, health facilities can help in health and social development as behaviours young people adopt during adolescence have critical implications for current and future health and mortality (Lloyd 2007).

1.6 ***Research Contribution to Knowledge***

The contributions of the current research to the ASRH knowledge will be twofold. First, the study will contribute to an in-depth understanding of the processes underlying social identities in shaping adolescent sexual behaviours.

Second, the study will also provide an in-depth understanding of the strengths and weaknesses of facility-based YFRHS as a strategy for delivering culturally contextualised ASRH services.

1.7 ***Scope of the Study***

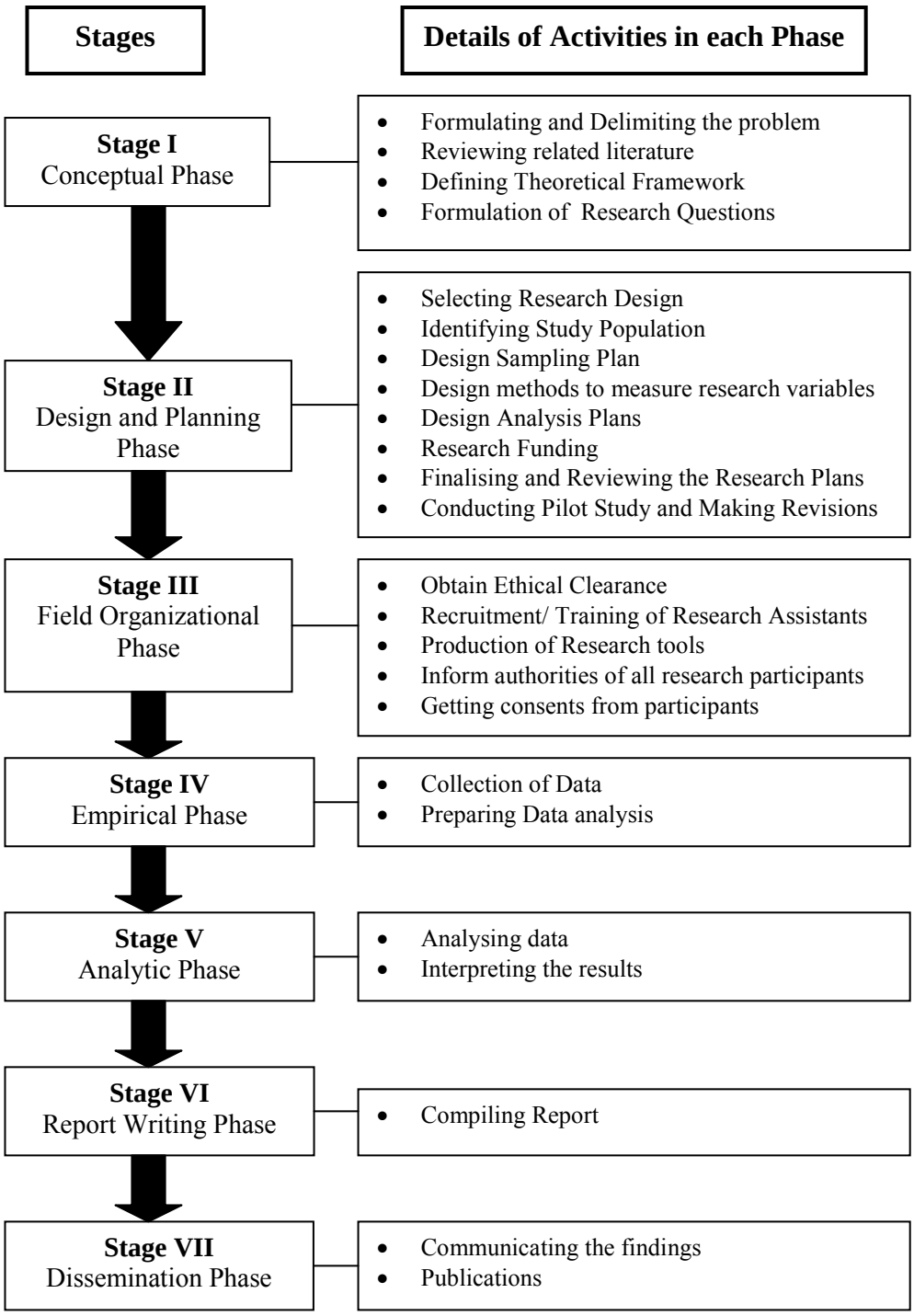
The study covered all ASRH activities supported by Nchanda ni Nchanda pa Umi Wambone (NnN) (Youth to Youth for Healthy Life), a YFRHS project funded by Save the Children Federation in Mangochi District. The activities aimed to improve knowledge, skills and attitudes towards ASRH; to increase the availability and accessibility of SRH to

adolescents, and to create a supportive social and policy environment for ASRH promotion in the society (SC/US 2004). Apart from the NnN activities, the study also covered all ASRH activities provided by other non-governmental organisations (NGOs), community-based organisations (CBOs) and the government public health programmes.

1.8 ***Research Process (For full details see Chapter 4)***

Research process is defined as the series of steps which make up research from the development of an idea to the completion of the research project (Polit and Hungler 1999; Polit et al., 2001). The research process in this study comprised seven distinct phases although the process was iterative (Figure 1.2)

Figure 1.2: Research Process



Adapted from Polit et al., 2001

Considering that the researcher conducted the study in a study setting where he was familiar with (home environment) and hence could be considered as an as 'insider' due to his sharing of some characteristics with the members of the study setting (previously

worked in the area as a health worker and manager, nationality, speaking common local language, meeting at some community activities like religious events), the importance of positionality was emphasised during the research processs to avoid biases the 'insider' positionality could bring to the study (see section 4.8.1).

1.9 ***Definitions of Terms Used in this Research***

1.9.1 *Youth-friendly reproductive health services*:

These are health facility-based sexual and reproductive health services provided to the adolescents in a youth-friendly manner. These services include provision of educational services, contraceptives, STI treatment, post-abortion and antenatal services. However, abortion services are not part of the services as abortion is illegal in Malawi (NYCOM 2001; JHPIEGO/MG/USAID 2001).

1.9.2 *Youth Friendly Reproductive Health Intervention Area*

These are areas (also referred to as '*intervention area*' in the thesis) with health facilities which have staff trained in the provision of YFRH services to the youth. These facilities included only those that provide all the SRH services without any limitations.

1.9.3 *Non-Youth Friendly Reproductive Health Intervention Area*

These are areas (also referred to as '*non-intervention area*' in the thesis) that have health facilities that do not have trained staff in YFRHS. Facilities nonetheless provide SRH services to the youth and the general population.

1.9.4 *Youth Friendly Reproductive Health Clinic*

These are clinics (also referred to as 'intervention facilities') that do have trained YFRHS providers working in the SRH department. These facilities do provide all the SRH services to all the population without any limitation.

1.9.5 *Non-Youth Friendly Reproductive Health Clinics*

These are clinics (also referred to as 'non-intervention facilities') that do not have trained YFRH providers. However, they may be providing other maternal and child health (MCH) and family planning services.

1.9.6 *SRH Behaviours*

SRH behaviours include use of modern contraceptives including condoms, primary and secondary abstinence. Condom use in this study refers to use of male condoms as no female condoms were available in Mangochi. Primary abstinence is defined as delaying initiating sex, while secondary abstinence means stopping having sex after one had already had the sexual debut.

1.9.7 *Facilities*

Facilities or health facilities are defined as hospitals and health centres that provide health services on a continuous basis. Thus, they do not include mobile centre because they are not always accessible to people in the catchment area they serve.

1.10 ***Synopsis of the Thesis***

The thesis has seven chapters. In order provide a background to the issues discussed in this thesis, chapter two and three will review in depth the social construction of adolescence and its implications for ARH promotion and approaches used in ARH promotion internationally and in Malawi respectively. Chapter two shows how the concepts of adolescence and sexuality are contested in most Malawian societies. It also shows that sexual norms in ambiguous and all these can challenge ASRH promotion in Malawi. Chapter three argues that though there have been several strategies to promote ASRH, most of them fall short of empowering adolescents, communities and health workers to effectively promote ASRH in Malawian society. The review in these chapters provides the theoretical foundation upon which this research is based.

Chapter four discusses the theoretical and methodological frameworks adopted in the study. It discussed how the frameworks informed the conduct of the research. This chapter argues that in order to understand the social determinants of adolescent sexual behaviours and the capacity of health intervention to promote ASRH, an interpretive research approach is essential. Use of social constructionist epistemology and social interactionism can be insightful in the understanding of social and cultural influence on behaviour.

Results of the study are presented in chapters five and six. Chapter five argues that social and cultural norms have a strong influence on shaping and promoting adolescent sexual and reproductive behaviour in rural Malawi where cultural adherence is a defining feature for morality. The chapter shows that social identities- ambiguous sexual norms, structural gender asymmetry and stigma strongly determined adolescent sexual practices in Mangochi.

The findings in chapter six argue that while local health facilities have been reoriented to address the SRH needs of adolescents, the reorientation has not empowered stakeholders (adolescents, communities and health workers/health facilities-policies) to effectively deliver activities that can promote SRH among unmarried adolescents. The chapter shows that SRH policies, laws, training of health service providers, organisation and delivery of SRH services for adolescents are not conducive for the promotion of ASRH. Furthermore, it shows that social norms directly and negatively affect the functioning of facility-based YFRHS in Malawi.

Lastly, chapter seven concludes by synthesizing the findings of the study, discussing their implications for YFRHS programmes and policies, particularly with regard to promoting the effectiveness of health facilities in ASRH, and identifying issues for further research. This chapter brings together the typological issues raised in chapters two and three and the study results in order to develop a new understanding of the current limited capacity of YFRHS to promote ARH among unmarried adolescents in Malawi.

. The chapter hence advocates that health facilities need to consider using Freire's conscientisation-oriented empowerment models within health promotion. In this way

various stakeholders (health workers, adolescents and communities) are enabled to disembed themselves from the social and cultural forces that limit their freedom to undertake health promotion activities.

1.11 ***Conclusion***

Overall, the ambiguous Malawian culture related to adolescence and sexuality and its implications for adolescent sexual and reproductive practices pose a challenge to policy makers and implementers in the promotion of ASRH. As such, this evaluation study of the impact of culture on ASRH with a focus on in-depth understanding of the effects of social and cultural norms on the functioning of YFRHS to promote ASRH is appropriate to address the research questions.

Chapter Two

Social Construction of Adolescence and its Implications for Adolescent Sexual and Reproductive Health Promotion

2.0 *Introduction*

The constructions of adolescence and adolescent sexual health are central to the discourse of ASRH promotion. The meanings of adolescence and ASRH vary across cultures and ethnic groups. Due to these variations, "*the lives and sexual and reproductive health needs of adolescents may vary considerably across these different groups, and programmes and interventions need to be designed to take that diversity into account*" (UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction [HRP] 2002:3). As such, understanding the conceptualisations of adolescence and sexual health in specific cultural context is necessary for effective ASRH programming.

Therefore, in this chapter I present the review of adolescence and sexual health in Malawi and in the western world. This chapter begins by discussing the notion of adolescence; then it examines how the western ideologies influence adolescence in Malawi. This is followed by a discussion on the notions of health promotion and sexual health promotion. Then the challenges the construction of adolescence presents to ASRH promotion are examined. The chapter concludes that understanding the social construction of adolescence is crucial for designing of effective ASRH promotion interventions.

2.1 *Social Construction of Adolescence*

2.1.1 *Definition of Adolescence*

Generally, adolescence is considered a time of transition from childhood to adulthood during which there are physical changes associated with puberty (Adamchak., et al 2000; Senderowitz and Paxman 1985). From this biological perspective, adolescence is defined as a period of lifespan of between the ages 10 to 19 years (IPPF 1994; WHO 2003b). The period of adolescence is characterised by a number of changes including physical and emotional changes, the search for identity and greater maturity in reasoning. It is considered as the period during which the individual progresses from the initial

appearance of secondary sex characteristics to that of sexual maturity, whereby individual's psychological processes and patterns of identification develop from those of a child to an adult (ibid.). Thus, adolescence is considered as a time of transition from childhood to adulthood, during which young people experience changes following puberty, but do not immediately assume the roles, privileges and responsibilities of adulthood (Caldwell et al., 1998; Jejebhoy and Bott 2003). However, defining 'adolescence' from the biological perspectives is problematic. The fall in the age of menarche from sixteen and seventeen in the mid nineteenth century to just under thirteen in 1960 can make definition of adolescents varying according to contexts (Cameron et al., 1991; Graham et al., 1999; Ganong 2002).

Socially, the notion of adolescence is not the same everywhere. Although the utilization of the concept of adolescence is so widespread in SRH literature, the term usually alludes to different phenomena. Because it is a culturally defined phenomenon, adolescence is a term whose meaning is variously defined in the literature (Dawes and Donald 1994; Schlegel 1995; Caldwell et al., 1998). Furthermore because adolescence is experienced differently in every society; and even within societies there may be vast differences in how some youth experience adolescence as compared to others (ibid.).

> Adolescents and young people are not a homogenous group; their lives vary enormously by age, sex, marital status, class, region and cultural context (UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction [HRP] 2002:3)

Due to the variations in the definition, adolescence is both a period of opportunity as well as time of vulnerability and risk. Schlegel (1995) defines adolescence as a life phase that involves the management of sexuality among unmarried individuals, social organisation and peer group influence among adolescents, and training in occupational and life skills. It is the time when new options and ideas are explored. As such, it is a phase in life marked by vulnerability to health risks, especially those related to unsafe sexual activity and related reproductive health outcomes like unwanted and unplanned pregnancy and STIs, and by obstacles to the exercise of informed reproductive choice (Millstein and Igra 1995; Munthali et al., 2004).

Furthermore, while most societies define the biological beginning of adolescence as coincident with onset of puberty, the time when adolescence ends and adult status commences is usually socially oriented and hence differs widely among cultures (Gyepi-Garbrah et al., 1985). Besides, the socially defined interval between childhood and adulthood may relatively be brief especially in societies where marriage, parenthood and increased social responsibility are assumed soon after puberty or menarche (Schlegel and Barry 1991). On the other hand, the interval between childhood and parenthood may be relatively prolonged as it is in industrial societies where social responsibility, marriage or parenthood are not assumed by young people soon after puberty or menarche (ibid.). Schlegel (1995) also argues that while the biology of adolescence could be constant, changes in the historical conditions of cultural and social life can lead to changes in the social organisation of adolescence that can reshape what adolescence means and how it is experienced in various societies.

Therefore, in various ways and for various reasons, the concept of adolescence is fluid. Adolescence as a biological concept may be misleading due to the variations in the social responsibility and cultural constructions in various contexts. Therefore, defining adolescence simply in terms of biological and chronological age is atheoretical and limits the potential for understanding underlying processes associated with adolescence for the production of sexual risk-taking behaviours. As such, Van Loon (2003) states that adolescence should be considered a phase rather than a fixed age group, with physical, psychological, social and cultural dimensions perceived differently by different cultures. However, as the notion of adolescence varies from society to society, this makes it increasingly difficult to provide any meaningful definition of adolescence and this explains why, for the most part, adolescents are defined as all those belonging to a defined age group (FHI 1993; 1997b); hence my decision to use age in my definition of adolescence (see 1.9.1).

2.1.2 *Adolescence as a Social Construct*

The concept of adolescence as a time a gradual transition from childhood to adulthood is relatively new in developing countries (Zabin and Kiragu 1998). In some societies in the developing countries, that stage of life called adolescence has not always existed as a

'construct' and its definition and even its existence has long been a subject of debate (Adamchack et al., 2000; Jorgensen 1993; Senderowitz and Paxman 1985). In most African societies, adolescence is equated to unmarried young people as Caldwell and colleagues noted

> Adolescence is often said not to exist in such relatively changing societies, and this idea is true in the sense that the unmarried young become, upon marriage, much like the older generation that preceded them. Nevertheless, great differences exist between the single and the married state,… (Caldwell et al., 1998:138).

Moreover, until recently, in many developing countries, especially in rural and underdeveloped areas, a girl has often been considered as an adult at the time when menstruation is established regularly because once menstruation commences, girls were expected to enter into marriage (Zabin and Kiragu 1998); as IPPF (1994:5) pointed out: "*In many societies a period of adolescence does not exist: children are regarded as adults once menstruation begins [sic], or when they have passed through a ritual ceremony or marriage*".

As a result of such constructions, some girls were being betrothed from childhood and most of them married soon after puberty in some African societies. In the polygamous societies, they became second or co-wives (Caldwell et al., 1998). Thus, in most traditional societies in Africa, reaching puberty is equated to becoming an adult. As such, the transition from childhood to adulthood among the girls has been quick, and the notion of adolescence has almost been non-existent (Senderowitz and Paxman 1985). This lack of adolescence in the developing countries was also reflected in the customs over the millennia that brought men and women into some form of union shortly after physical maturation based on the assumption that some form of sexual activity is normal after puberty (Jorgensen 1993). On the other hand, young men's sexuality was accepted and was in some polygamous societies they were allowed to have discreet access to the younger wives of older married brothers or even their fathers. Other possible sexual relationships were with cousins or other relatives (Caldwell et al., 1998).

While adolescence is a culturally determined phenomenon, its construction has changed in the developing world. The conceptualisation of adolescence has altered dramatically over the century in consequence of economic, social, institutional, moral and political changes

brought about by western colonial and economic expansion and by the move toward a global economy and society (Morrow and Richards 1996; Jones and Wallace 1992; Caldwell et al., 1998). For instance, it has been reported that due to education that has brought along long period of schooling, many young people have long period of non-marital status (ibid.). Moreover, the creation of a capital economy and the increased urbanisation led to new jobs, many of which required education beyond the primary level (Caldwell et al., 1998). Such developments presented adolescents with freedom to move out of the traditional system of socialisation by removing young people from their houses and farms to schools and other places, providing them with information often at odds with parental instruction, and permitting young people of both sexes to meet without family supervision (ibid; Kiragu and Zabin 1995).

Apart from education, religion facilitated the social change in most societies in the developing countries (Caldwell et al., 1998). Religion for instance brought in western cultures that brought in messages including sexual messages that were at odds with the traditional messages. Christianity raised the fear of the threat of early childbearing besides bringing messages prohibiting premarital sex (ibid.) Thus, religion facilitated the establishment of the long period of non-marital status among young people as they were being obedient to their religions (Monfort Press undated; Caldwell et al., 1998; Byamugisha 2000; Ham 2004), while on the other hand, globalisation exposed young people to sex and SRH information that could potentially influence their sexual behaviours.

As these changes have also influenced the access to sexual information (Hawkins and Meshesha 1994; Kiragu and Zabin 1995; Munthali et al., 2004), these changes have potentially placed young people at risk of SRH problems because global changes have affected people's social identities which now encourage early marriages as a means to avoid premarital pregnancies. Other evidence also indicate that more young people around the world are more and more likely to be sexually active outside marriage, as a result of economic conditions, peer pressure, mass media influences, migration, and other forces of social change (Hawkins and Meshesha 1994; PRB 1992; Robey et al., 1992).

2.1.3 *Contextualising Adolescence in Malawi*

As in other countries, adolescence in Malawi is considered as the transition period from childhood to adulthood (Munthali et al., 2004; CRH 2005). In most societies, transition from childhood to adulthood is marked by initiation rituals in which young people are advised on several traditional issues including relationships, sexuality, reproduction and family matters (Maliwa 1978; Phiri 1997; 1998). Adolescence in Malawi is a period when social identities associated with being male or females are reinforced. During this time, male dominance in sexual issues is promoted among adolescents. Boys are taught about their decision-making role in sexual issues and other characteristics of masculinities like having multiple partners (CSR 1997; Munthali et al., 2004). On the other hand, submission in every way to their male sexual partners is encouraged among girls: "*The girl was told never to argue with her husband and to treat him like a king*" (Phiri 1998:132). Besides, girls are encouraged to be modest and avoid male company, not to master the dynamics of conversation and social interactions between males and females (CSR 1997; Alam et al., 1990).

Moreover, gendered roles in production are emphasised throughout the socialisation in Malawi. Adolescent boys and girls are socialised differently on their productive roles. Rural adolescent males are taught and encouraged to become independent, managing their own lives with some material and economic support from their parents. Many do piece work to earn money to meet their basic needs (CSR 1997). On the contrary, girls are socialised to help their mothers with non-paying household chores. Hence, girls cannot be independent economically and materially and have to depend on their male partners for their living (ibid.). Because of this, most female adolescents succumb to their male partners' sexual wishes in order to gain their support (CSR 1997; Masanjala 2007).

While sexual activity is not formally sanctioned among the unmarried young people (Helitzer-Allen and Makhambera 1993; Stewarts et al., 1998; NSO and ORC Macro 2001; Munthali et al., 2004), some social traditions including initiation and cultural cleansing rituals encourage young people to have unprotected sex (CSR 1997; Munthali et al., 2004; CRH 2005). In some societies like the Chewa, sexual activity is the only sign of the transition to adulthood: "*for girls, sexual rites were performed between the initiates and*

unknown men (fisi) to mark the end of puberty initiation" (Phiri 1998:131). The importance of initiation rites was also emphasized by Verstraelen-Gilhuis (1982:85): "*Without passing through chinamwali*[5] *it was not possible to be accepted as a fully adult woman in Chewa society*". On the contrary, some anecdotal observations reveal that among the Yao tribes, the phase of adolescence only exists for boys. Girls do not have a phase called adolescence, probably because they are expected to marry soon after puberty "*Mau oti nchanda amatanthauza nyamata wocheperako. Mtsikana samakhala nchanda ayi. Akatha msinkhu ndiye kuti wakula basi*" (*The concept of adolescent does only apply to boys; girls do not pass through that phase. It only means a young boy. After menstruation commences, a girl becomes a grown-up*" (Chief Mpondasi, personal communication, December 2004).

Moreover, while premarital sex is not allowed and childbearing outside wedlock is undesirable, messages encouraging sexual activity and the importance of childbearing, rearing children and managing family affairs are passed to the young people at early stages (Phiri 1998; CSR 1997). This causes ambiguity in the culture about adolescence and premarital sexual relationships.

Furthermore, the signs of completion of transition are marked by pro-fertility attributes in most Malawian societies. For instance, while giving birth is a sign of the completion of transition among women, becoming a father to a child is a sign of completion of transition among the boys (Phiri 1998; CRH 2005). This can however lead to problems in designing health promotion programmes that can reach all adolescents as those between 10-19 years but have babies are not considered as adolescents.

Like in other parts of the world, the role of the Malawian societies in socializing the youth has changed due to globalization. While initiation rites have been the main institutions for socialisation, there are now fewer initiation camps than before which might result in low coverage of youth being advised about sexuality and reproduction (CSR 1997; Munthali et al., 2004). Moreover, the society which has its own traditional advisors to socialise young people on sexual and reproductive issues has also handed over their socialization

[5] *Chinamwali means initiation*

roles to the modern structures such as schools and religious institutions (Yinger et al., 1992; Kiragu and Zabin 1994; CSR 1997; Munthali et al., 2004). Thus, the traditional structures such as initiation rituals have been weakened by the western religions and education systems which usually do not provide sex education due to values held by the religious-influenced institutions (Montfort Press undated; Byamugisha 2000; Munthali et al., 2004; Ham 2004). This has however created a vacuum for young people's sexuality education because the traditional socialization structures have, to a large extent, been disintegrated (Chimbiri 2002; Pathfinder International 1998a).

Moreover, due to globalisation which exposes many adolescents to sex information and also takes them away from their parents due to schooling, it is evident in most Malawian societies that sex has become an aspect of individual pleasure and gratification as well as reproduction (Hickey 1997). In other words, sex to some boys and girls is a matter of recreation at the expense of moral duty and responsibility (CSR 1997; National HIV/AIDS Planning Unit 1998; NACP/MoHP 1999). Thus, globalisation has facilitated the shifting of perceptions of sex as a part of procreation due to sharing of cultures through media and this has an influence on adolescent sexual behaviours in Malawi (Hickey 1997).

Despite the societies' awareness that unprotected premarital sex is common and can increase adolescents' vulnerability to SRH problems, traditionalists still object to the promotion of activities that are seen to empower young people to control their sexual lives such as sex education and unrestricted access to SRH services (ibid; MOEST 2002). However, the same activities are encouraged in some socialisation circles like initiation and cleansing rituals (Munthali et al., 2004). This portrays the ambiguities in the culture in Malawi which can perpetuate the adoption of unsafe sexual practices.

From the evidence above, it is obvious that contextualisation of adolescence in Malawi disempowers some adolescents from controlling their sexual health due to either norms that compromise female adolescents' power to refuse sexual advances from male partners or negotiate for protected sex or influence of social identities or traditions that force young people to take certain socially accepted behaviours (CSR 1997). Besides, social

construction of adolescence also creates an ambiguous sexual identities that could increase adolescents' risk-taking behaviours and reduce their agency for health promotion.

2.2 ***Sexuality, Sexual Behaviour and Risk-Taking***

2.2.1 *Sexuality and Sexual Behaviour*

Sexuality is one of the issues affecting sexual health in most countries (UNFPA 2003; Chege 2005; Chimbiri 2002; 2007). The definitions of sexuality vary from one professional field to another. The contemporary belief views sexuality as a fixed essence that resides within the individual (D'Emilio and Freedman 1988). Goettsche (1989) defines sexuality as "*the individual capacity to respond to physical experiences which are capable of producing body-centred genital excitation that only subsequently becomes associated with cognitive constructs (either anticipatory for new experiences or reflective of past experiences), independent of ongoing physical experiences*" (p.249). Individual capacity in this case refers to sexuality as emerging within each person, as opposed to coming from external forces (ibid.). This conceptualisation of sexuality considers sexual behaviour as body-centred, meaning that it is experienced through the body regardless of its source which can be environmental, by self-stimulation, by another person, by unconscious muscle contractions and even by memories of past sexual experiences. This makes sexuality to be always be defined in terms of genital stimulation and orgasms regardless of the cultural variations in sexual definitions (Goettsche 1989). Thus, the essentialist model looks at sexuality as an internal or biological force that can only be biologically manipulated, controlled or regulated. However, this essentialist framework overlooks the ways in which sexuality is constructed in the society. It also ignores the fact that sexuality can be grounded in economic change and its roles in maintaining systems of social inequality (D'Emilio and Freedman 1988). In this case, using a biological focus on sexuality, that's, defining it as an inherent, uncontrollable force trivialises and mystifies the social and psychological aspects of sexuality (Tiefer 1987; 1991).

According to the Options for Sexual Health (2008), sexuality is not just about sex, though people usually define sexuality in terms of genitals, what people do with them, and who they do it with. Sexuality involves and is shaped by many things including values and beliefs, attitudes, experiences, physical attributes, sexual characteristics and societal

expectations (ibid.) Foucault (1978) also in his book "*History of Sexuality: An Introduction*" argued that there is no such thing as an internal force or drive that can be manipulated in the ways that can change sexuality. He instead stated that what can be manipulated are ideas, definitions, which regulate the ways in which sexuality can be thought of, defined or expressed. According to Foucault, cultures construct the rules, beliefs, values and acceptable behaviours, all elements that underlie the discourse and regulation of sexuality (Goettsche 1989). Goettsche (1989) and Tiefer (1995) also emphasise the importance of culture in defining, shaping and promoting sexuality, including the maintenance of socially stigmatised patterns- all of which can affect sexual health. Thus, sexualities can constantly be produced, changed, modified and the nature of sexual discourse and experiences changes accordingly. Goettsche added that the significance of the social definitions is that people have to define actions as sexual before being able to engage in such sexual acts (Goettsche 1989).

Based on Foucault conceptualisation of sexuality, sexuality in this thesis is viewed as a socially constructed concept whose understanding and constructions are essential to comprehend the complexities of cultural influences on sexual behaviours. Sexuality is therefore "*emphasises the sexual knowledge, beliefs, attitudes, values and behaviours of individuals, and is an integral part of the personality of every human being*" (Ford Foundation 2005:18). Thus, sexuality is more than what one does with another person sexually. It is not only about having sex, or taking part in sexual behaviours but it also about how the person feel you are, your body, how you feel as a boy or girl, man or woman, the way you act and feel about other people and how such factors impact on sexual behaviours (Tiefer 1995; Stedman's Medical Dictionary 2006; Options for Sexual Health 2008). Ng, Borras-Valls, Perex-Counchillo and Coleman (2000) describe sexuality includes values regarding relationships, dating, marriage, sexual ethnics, sexual culture, psychology in relation to gender, sexual role , physical factors such as sexual characteristics, sexual drive, sexual intercourse, sexual activities and sexual orientation that can be heterosexual, homosexual or bisexual.

Sexuality develops through the interaction between the individual and social structures influenced by ethical, religious, cultural and moral factors (LaRossa and Reitzes 1993.). Sexuality is socially constructed in terms of psychological, social, political, cultural,

spiritual/religious and economical aspects of sex and human behaviour (Fine 1993; Options for Sexual Health 2008). As noted in other studies, sexuality can be described as the expression of identity through gender (male/female) (LaRossa and Reitzes 1993; Chege 2005; Chimbiri 2002; 2007). However, the socially constructions of sexuality encounter heated debates among different institutions especially the traditional, religious and donors (see section 1.2) within a society and this can influence the adoption or support of safe SRH behaviours. Because of the variations in cultures and the values associated with cultures, sexuality influence sexual behaviours and acts which can eventually affect sexual health.

Sexuality is driven by two perspectives in most African societies to influence sexual behaviour: personal agency and inevitability perspectives (Kaler 2004). According to inevitability perspective, sexuality is part and parcel of humanity. From this view, sexual behaviour is seen as influenced by nature which is often irrational force that could not be resisted (Mtika 2001; Setel 1999). In societies holding this view, SRH problems are considered a part of life and in some instances; problems also are a measure of success in one's life-time (Kaler 2004). For instance, in some societies getting an STI in men is considered normal and a sign of success (Palamuleni 2002). For girls, becoming pregnant is a sign of maturity and in some societies; it initiates conduction of festivities indicating transition from adolescence to adulthood (Verstraelen-Gilhuis 1982; Caldwell et al., 1998; Phiri 1998; CRH 2005). In this case, health promotion about safe sex among adolescents could appear 'unnatural', coming from a realm outside the normal course of adolescent life (Kaler 2004).

Agency perspective on the other hand, focuses on ways one's own behaviour changes to protect oneself from SRH problems (Kaler 2004). Thus, there are some individuals in the society who believe that changing their sexual behaviour could protect them from SRH problems. Although this driver of sexual behaviour is also common in Malawi, the measures adopted cannot guarantee protection of the people. For instance, Kaler (2004) observed that in the hegemonic-oriented context of Malawi where males were socialised to control sexual issues, males talked of three forms of behaviour change: "*being more selective about their sexual partners; reducing the number of partners they have; and*

using condoms" (p.292); partner selection is the most common form of behaviour change while condom use is the least popular and most references to condom use are disparaging due to culture which emphasises on masculinity attributes (Kaler 2004). Similar observations were also made in Tanzania (Ng'weshemi et al., 1996). This evidence means that effective SRH health promotion interventions may need to bring in radical change that would encourage the communities to have critical consciousness of their personal agency in order to transform their social reality so as to avoid the risks that may be associated with their social identities (Freire 1973).

2.2.2 *Discourse of Adolescent Sexual Risk-Taking: Nature or Nurture?*

Adolescence is associated with risk-taking behaviours and they tend to increase in prevalence over the adolescent years (Elliot 1993). Adolescent sexuality is one of the behaviours which has for along time been viewed with much ambiguity in a large part of the world (Dehne and Riedner 2001). Though science and medicine frame sexual acts in apparently a biological model and describe sexuality in biological perspectives that gives SRH appearance of moral neutrality (Adams and Pigg 2005), others situate adolescent sexuality within the framework of deviant behaviour in the sociology and psychology fields (McCauley et al., 1995). However, other writers argue that the construction of certain behaviours as deviant or unsafe is problematic (Dehne and Riedner 2001) probably because of the variations in the constructions between epidemiological and social perceptions of risk. From a sociological perspective, a risk is a decision-making situation in which various probabilities are attached to possible outcomes of future events (Lopes 1987). Epidemiologically, a risk is defined in statistical term

> The degree of increased risk associated with a specific behaviour or other factor is measured as the relative risk or relative odds of infection comparing those with the factor to those without the factor (Brookmeyer and Gail 1994:23).

Despite this commonly used epidemiological view, Lupton (1999; 1995) argues that people interpret epidemiological risks within their own behavioural landscape and according to their own circumstances and priorities. This means that understanding the social construction of risk is important in designing interventions that aim to reduce SRH risks in specific context as that would also affect people's agency for health promotion activities.

Despite people's conceptualisation of adolescent sexuality, significantly, more adolescents engage in sexual behaviours that could put them at a higher risk of getting sexual and reproductive health problems (United Nations 1996). In particular, increasing concern is being expressed about sexual risk-taking among young people and consequences of such behaviour as teenage pregnancy and the incidence of sexually transmitted infections, including HIV (ibid.). As such, understanding the genesis of SRH risk-taking practices among adolescents has become a concern for most health policy makers in both developed and developing countries (UNFPA 2003; United Nations 1995a; 1995b). This has been so due to the realisation that the implementation of ASRH programmes that only superficially address cultural factors in the context of practice and not at all in the context of adolescents' attitudes and beliefs (Nduat and Kiai 1997) has not helped to reduce the situation. Moreover, lack of understanding on the theoretical basis for adolescents' behaviours could also lead to faulty planning of health promotion activities aiming to address SRH issues among adolescents (ibid.). As such, there is need to understanding the etiology of risk-taking in adolescence in order to design effective ASRH interventions.

There is a growing body of literature which problematizes the notion of childhood, and by implication adolescence (Kandel and Logan 1984, Halperin et al., 1983; Blum 1991; Brindis et al., 1992; Smart 1996). Health data of adolescents also indicate that many of the primary threats to adolescent health are preventable behaviours including sexual behaviours, substance use and injury-related behaviours (ibid.). Moreover, other evidence reveals that the rates of such behaviours increase in late adolescence and declining in young adulthood (Kandel and Logan 1984, Halperin et al., 1983). Due to this situation, other writers attribute adolescent lifestyles to nature while others argue for nurture in attempt to explain the discourse of risk-taking behaviours.

According to developmental psychologists and scientists, the '***nature'*** perspective views emergence of risk-taking behaviours as being due to the specific psychosocial and cognitive development or changes that characterise the adolescent period (Burman 1994). Among others, neurones and hormone influences are associated with the timing of pubertal events (Millstein and Igra 1995); genetic predisposition has been implicated in

adolescent alcohol abuse (Cloninger 1987) and the importance of testosterone levels to heterosexual intercourse and the onset of other risk behaviours in males (Udry 1988; 1990; Udry et al., 1985) and females (Udry et al., 1986; Udry and Billy 1987) have also been documented.

Moreover, recent brain science suggests that an enormous amount of development occurs in the adolescents' brain's frontal lobes: the centre for planning, understanding cause and effect, foreseeing consequences, and controlling impulses - "*the brakes of the brain*" (Johnson in Hendricks 2005:39). The bottom line, she adds: The frontal lobes "*are a work-in-progress until the early 20s*" (ibid.). In this way, cognitive development could be at the centre of influencing risk-taking through the perception of risks and vulnerability and decision-making (Furby and Beyth-Marom 1990).

> Risk-taking and experimentation during adolescence are considered normal behaviour because they help adolescents achieve independence, identity and maturity (Jack 1989:337).

McCandless and Coop (1979:296) also wrote

> Testing and experimenting with sex is normal in adolescence. It is one means by which adolescents accomplish the developmental tasks of incorporating their new awareness of sexuality into their self-concept …

Evidence from other sources also demonstrated that while risk-taking could lead to problems and that adolescents are very much aware about the consequences of their behaviours, they still do them (DiBlasio 1986; Irwin and Millstein 1987; Klintzer et al., 1987). Moreover, there is growing support for the possibility that adolescent risk-taking is a reasonably rational and thoughtful process (Furby and Beyth-Marom 1992; Gardener 1993; Lopes 1993). This evidence suggests that risk-taking behaviour is a function of nature that may not be controlled.

While other research suggests that sexual expression is greatly influenced by hormonal changes that occur naturally during maturation (Udry 1988; 1990; Udry et al., 1986; 1987; 1995). Brooks-Gunn and Furstenberg (1988) argued that social environments may still define boundaries for the expression of hormonal influence. For instance, although there is a link between testosterone and sexual behaviour among males, it appears to be

mediated by the social environment among females (Udry et al., 1986; Udry and Billy 1987). This means that nurture perspective is also applicable in sexual behaviour development.

The '***nurture***' perspective of adolescent lifestyle attributes risk-taking to dispositional and ecological based theories (Millstein and Igra 1995). According to sociologists, the lifestyle of adolescents as a social group characterises the totality of patterns of meaning and forms of expression which are produced and reinforced by a group in the course of collective efforts to cope with the demands and contradictions of the social structures and circumstances common to all members of that group (Franzkowiak and Wenzel 1994).

Dispositional based theories view risk as deviant and pathological, a reflection of maladaptive functioning due to some deficits within an individual (Millstein and Igra 1995). These deficits may be hypothesised deficits such as poor self-esteem (Kaplan 1980; Kaplan et al., 1987), depression (Petersen et al., (1993) inadequate social skills (Botvin 1986), impulsivity (McCord 1990) or general propensity for unconventionality and deviance (Donovan and Jessor 1985; Osgood et al., 1988). The deficits may also sensation seeking. That is, individuals differ in terms of their underlying need for stimulation and that sensation underlies much of the risk-taking behaviour (Zuckerman et al., 1990; Tonkin 1987).

Ecological based theories view social and environmental contextual factors such as economic status, cultural background, and the general social environment provide social norms, models, opportunities and reinforcements for adolescent participation in unsafe behaviours (Millstein and Igra 1995). Thus, the elements of social environment with which adolescents interact directly with shape, reinforce or influence adolescents' behaviours. These may include proximal factors such as peer pressure (Brown 1990), parenting styles (Baumrind 1991) and lack of supervision by parents on their children (Hayes 1987; Mosher and McNally 1991; Turner et al., 1991; Flewelling and Bauman 1990) and role modelling (Evans and Raines 1982; Elliot 1993).

Additionally, distal social contexts such as community, mass media and social policies are also associated with influencing risk-taking behaviour among adolescents (Millstein and Igra 1995; Perry et al., 1993; National Research Council 1993). This could be explained by the fact that presence of certain environments could promote risk-taking that may be through either increased access to certain items (e.g. cigarettes or alcohol) or other motivations (Barnett and Whiteside 2002; Crockett and Petersen 1993). For instance, certain unsafe behaviours such as unprotected sex may be used as a rational coping strategy adopted in the context of economic hardships (Graham 1993). In this way epidemiological risk factors may be overridden by more immediate risks and more urgent problems (Naidoo and Wills 1998). This model implies that creation of risk free environment could assist in promoting healthy behaviour among adolescents (Barnett and Whiteside 2002).

Altogether, the analysis of the above available evidence sustains two broad conclusions about risk-taking, both of which could have major implications for the ASRH promotion. That is, adolescence has two foci of control: nature and nurture. However, the determinants of the lifestyles in these two areas are interrelated and interconnected (Udry et al., 1986; Udry and Billy 1987). A critical analysis indicates that adolescent life style is largely influenced by the social environment. Thus, the nurture and nature perspectives of risk-taking have social influence playing a role in shaping the behaviour. Due to the centrality of social environment in shaping lifestyle, this might imply that health promotion that fails to address the social contextual determinants and instead only focus on individual responsibility could be ineffective (Coreil et al., 1985; Backett and Davidson 1995).

2.3 ***Sexual Health Promotion: Definitions of Concepts***

2.3.1 *The Concept of Health*

Health is a broad concept which can embody a huge range of meanings ranging from narrowly technical to the all-embracing moral and philosophical. The word health has its roots in the word ‘heal’ which originally meant ‘whole’ and the Greek ‘holos’ which also means ‘whole’(Hoad 1986). Thus, health considers the human in entirety as inner dialogue and a social being. Hippocrates, who is traditionally considered as the father of

medicine, also described health as a condition in which the functions of the body and the soul are in harmony with the outside world (Nilsson and Petterson 1998).

However, there are now a number of definitions of the concept of health available in today's extensive literature. The definitions can be viewed from two perspectives: disease-oriented and a holistic perspective.

The disease-oriented perspective is represented by the philosopher Boorse who said that health implies freedom from disease and that a person is in good health when his body and soul function normally (Boorse 1977). This is also adopted by the western scientific model of health which often refers to health as '*no disease or no illness*' (Naidoo and Wills 2000:9).

The holistic perspective represented by Porn (1995) describes health a state in which the individual has a repertoire of necessary resources for healthy life. Nordenfeldt (1987) also pursues similar reasoning and describes good health as being related to the extent to which the individual can realise his/her vital goals under normal circumstances. Likewise, the WHO (1946) defined health in its constitution as a 'state of complete physical, mental and social well-being, not merely the absence of disease or infirmity'.

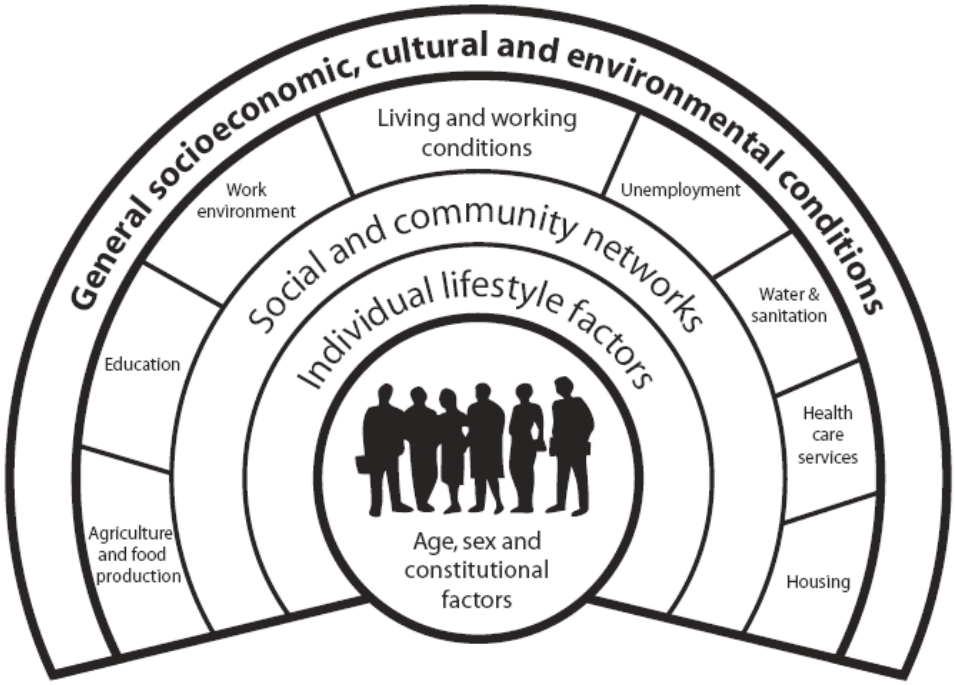
However, the WHO conceptualisation of health as an ideal state of physical, social and mental wellbeing that enables people to fulfil their health needs has been criticised for not taking into account other dimensions of health, namely, emotional, spiritual and societal aspects of health (Aggleton 1991). Moreover, the definition has also been criticized for viewing health as a state or product rather than as a dynamic relationship, capacity, a potential or a process. But mostly, the definition has also been criticized for specifying an idealistic state that may be impossible to attain considering the other factors not considered in the definition (ibid.).

While health is viewed by biomedical scientist as an objective reality, this view seems deficient in health promotion as other writers have demonstrated the importance of social model of health

> This process [definition of health] becomes most apparent when doctors and their patients disagree about the significance or meaning of symptoms. For example, someone can feel ill but after investigations nothing medically wrong can be found. The subjective experience of feeling ill is not always matched by an objective diagnosis of disease (Naidoo and Wills 2000: 7-8).

Thus, the scientific conceptualisation of health lacks a social dimension which needs to be considered for effective health promotion. As such, this study adopts Dahlgren and Whitehead's (1991) social model of health (SMH). Social model of health views that ASRH improvements or health outcomes are a product of the interactions between individual, community and socio-economic factors surrounding an adolescent. According to Dahlgren and Whitehead, determinants of health are multifaceted and multi-layered. These factors include individual, community and policy factors such as political environment which interrelate with socio economic environment, individual lifestyle behaviour and access to effective health care-see Figure 2.1.

Figure 2.1: Factors Influencing Health



Sources: Dahlgren and Whitehead 1991

Based on the social model of health, a health promotion can therefore be achieved by understanding the ecology of health and the connectedness of the biological, behavioural, physical and social economic domains. These factors can either promote or reduce an adolescent's health (ibid.). Based on the potentiality of these factors to affect health in either way, Bates and Winder (1984:36) define "*health as the capacity to cope with or adapt to disruptions among the organic, social, and personal components of the individual's health system*". This means that promoting health requires action that would create health promoting environment within all these layers of influence. Ideally, therefore an effective YFRHS have a crucial role in identifying and responding to local issues that affect adolescents' sexual behaviours. However, because health promotion is carried in social contexts with varying variables that may affect health, a more holistic approach to address the various determinants of health and lifestyles is essential if health initiatives are to achieve health promotion goals (Naidoo and Wills 2000; Tannahil 1985; Laverack 2004; Nettleton 1995).

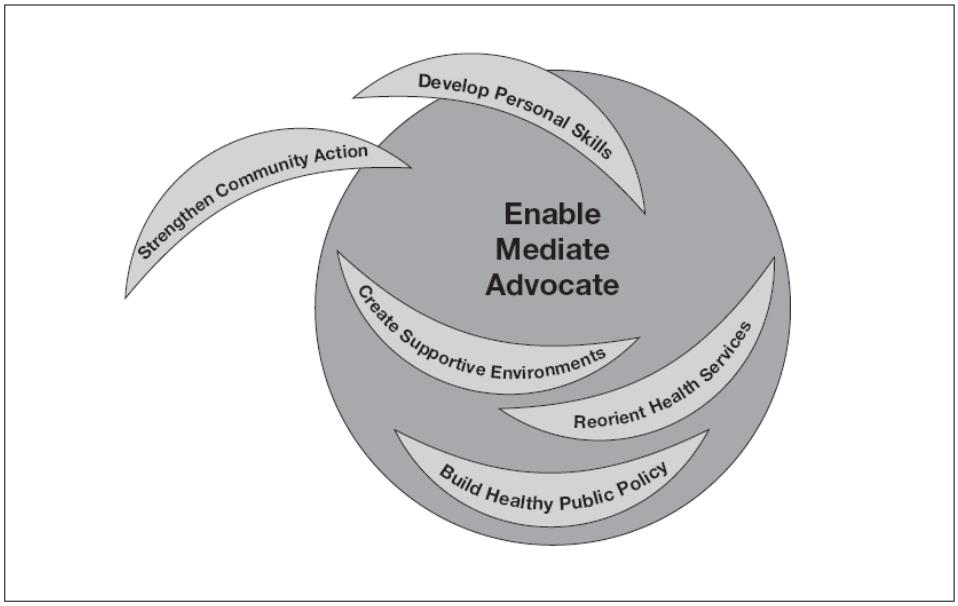
2.3.2 *The Concept of Health Promotion: Ottawa Charter Perspective*

According to WHO (1986a; 1986b), health promotion aims to enable people to achieve their highest standard of health and well being. As health is influenced by various factors in the society (Dahlgren and Whitehead 1991), health promotion should aim to meet all aspects of human well-being. According to Doyal and Gough (1991), well-being is the ability of people to participate in life which can be achieved through the fulfilment of two basic needs: the need for health and the need for autonomy. Autonomy literally means self-rule. This means that health promotion should enable people to fulfil these basic needs so that they can achieve good health.

Therefore, this thesis adopts the Ottawa Charter for Health Promotion's definition which describes health promotion as "*a process by which people are enabled to increase their control over the determinants of health, and improve their health*" (WHO 1986a:1). While various definitions of health promotion have been proposed over the past decades and share the element of the enabling process (Rootman et al., 2001; Bunton and Macdonald 2002; Green and Kreuter 1991; Tannahill 1985; WHO 1986a; Nutbeam 1985), the Ottawa Charter of Health Promotion (WHO 1986a) further defines health promotion to involve a

diverse set of actions focused on individual, community and health institutions or environment, which through increasing their capacities on health promotion could ultimately enable, mediate and advocate for their agency for health promotion (Kickbusch 1994; Rootman et al., 2001a; 2001b). Thus, the Ottawa Charter of Health Promotion's five components essential for health promotion: developing personal skills, strengthening community action, creating supportive environments, reorienting health services and building healthy public policy (WHO 1986a; 1986b) can together mediate, advocate and enable people to take actions to promote ASRH (Figure 2.2).

Figure 2.2: Essential Elements of Successful Health Promotion



Adopted from NSW Department of Health 2002:9 (adapted from WHO 1986a)

These components of health promotion together aim to help people change their lifestyle through efforts implemented to enhance awareness and create environments that support positive health practices that may result in reducing health risks in a population (Bunton and Macdonald 1992; Green and Kreuter 1991; Tannahill 1985). Among adolescents, it aims to help adolescents gain and increase control over the determinants of their health and influencing their lifestyles to be conducive to health (Franzkowiak 1990; Nutbeam and Blakey 1990; Erben 1991). Thus, these components aim to empower individuals, communities and health sector so that they can together promote health (WHO 1986). According to Bunton and Macdonald (2002), health promotion empowers people to

improve and maintain health through disease prevention, health enhancement, and medical care.

As presented above, health promotion represents a comprehensive social and political process that not only embraces actions directed at strengthening the skills and capabilities of individuals and communities, but also action directed towards changing social, environmental and economic conditions so as to alleviate their effects on public and individual health (WHO 1986a; 1986b).

Moreover, health promotion is based upon a combination of actions by individuals, communities and governments designed to have optimal impact on lifestyles and living conditions which influence health status and quality of life (Nutbeam and Blakely 1990). Therefore, health promotion initiative should empower/enable individuals, families, groups and communities to optimise their health and well-being whatever their needs or stage of development (Simnett 1995). In other words, health promotion is equated to empowerment for health.

2.3.3 *Conceptualising Empowerment in Health Promotion*

Empowerment is a term that has become very popular in health promotion. The notion of empowerment is central to health promotion as embraced in the Ottawa Charter of Health Promotion (WHO 1986a; 1986b). Reference has been made to the Ottawa Charter's emphasis on the virtues of empowered and participating communities and individuals in health promotion (WHO 1986a; Tones and Green 2004). Despite the emphasis of empowerment in health promotion, its meaning varies from one intervention to another. Common key elements of empowerment outcomes identified in health promotion interventions include access to information, ability to make choices, assertiveness and self-esteem (Chamberlin 2008). In SRH promotion, empowerment has been associated with activities like SRH education, gender equality promotion or increased access to SRH services (UNFPA 2003). However, as empowerment is central to health promotion (WHO 1986a), understanding the meaning and processes of empowerment is essential in strategising effective health promotion initiatives.

The World Bank defines empowerment as the process of increasing the capacity of individuals and groups to make choices and to transform those choices into desired actions and outcomes (World Bank Group 2008). Page and Czuba (1999) defined empowerment as a multi-dimensional social process that helps people gain control over their own lives. Empowerment fosters capacity to implement (power) in people, for use in their own lives and in their own societies by acting on issues that affect them (ibid.). Similarly, Kabeer (1999) views the idea of power as being central to empowerment. As such, one way of conceptualising power is in terms of ability to make choices: "*to be disempowered, therefore, implies to be denied choice*" (p.2). Thus, according to Kabeer, the notion of empowerment is antagonistic to disempowerment. She therefore defines empowerment as "*the processes by which those who have been denied the ability to make choices acquire such ability*" (Kabeer 1999:2). In other words, processes of empowerment entail change at different levels where choices are denied. The complex of causal factors resulting in the denial of choice can be conceptualized in terms of structural relations of class/caste/gender at deeper level, distribution of rules and resources at intermediate level and individual agency at immediate level (Kabeer 1999). This means that in any society, social structures including norms, rules, class, access to resources and other social issues can lead to disempowerment. As such, empowerment needs to take a holistic approach and should recognise that biological, psychological, social and economic aspects of individual are interconnected and affect the overall health and well being of individual (Arai 1997; Dahlgren and Whitehead 1991).

As the WHO (1986) definition of health promotion requires empowerment of individuals, communities and health facilities in order to effect health promotion process, McWhirter (1994) therefore summed up the definition of empowerment as

> the process by which people, organisations, or groups who are powerless or marginalised (a) become aware of the power in their life context, (b) develop skills and capacity for gaining some reasonable control over their lives (c) which they exercise, (d) without infringing upon the rights of others and (e) which coincides with supporting the empowerment of others in their community (p.12).

Notably, this definition realises the importance of identifying the most relevant systematic and structural influences on individuals' lives at personal, interpersonal and societal level that make them powerless and enable them to act on those influences that negatively

affect people's health without infringing on other people's rights (ibid.). Thus, empowerment entails a process of change including the social contexts in a way that will enable people to control their actions and increase their control over their lives.

Social structures can affect health promotion because they can affect agency. Social norms affect power related to agency. Kabeer (1999:4) defines agency to refer to "*people's capacity to define their own life choices and to pursue their own goals, even in the face of opposition, dissent and resistance from others*". Thus, agency is the ability to define one's goals and act upon them. It also encompasses the meaning, motivation and purpose that individuals bring to their activity. Agency is often operationalized as decision making ability (Kabeer 1999). In this case, empowerment should give people agency to make healthy choices that can promote their health regardless of social forces. This can take the form of bargaining and negotiation, deception and manipulation, subversion and resistance as well as more intangible, cognitive processes of reflection and analysis (ibid.). Empowerment can be exercised by an individual or by groups. Agency in the community empowerment can help people to provide mutual support that can help to promote individual empowerment but also create a supportive environment where health promotion can occur (Kickbusch 1996).

While many empowerment programmes in health focus on issues of governance, policies, strengthening civil society and many others (World Bank Group 2008), social norms in most societies limit the capacity of people to control their actions (Kiragu and Zabin 1998; Chege 2005; Chimbiri 2002; 2007). People act based on the social expectations and not according to their awareness of the threat their actions would cause to their lives (Zabin and Kiragu 1995; CSR 1997). In this case therefore, empowerment needs to be considered in terms of enabling people to act free of social and moral values that restrict or limit their agency for health promotion. Empowerment should enhance people's ability to take responsibility for making healthier choices, resisting negative pressures, and avoiding risk behaviours (Philliber Research Associates 1997; UNAIDS 2000; CEDPA 2000). Therefore, unless the concept of empowerment embraces social transformation through critical consciousness of the social reality (Freire 1973), social values will continue to negatively affect the people's agency for health promotion (Stead et al., 2000).

This is so because society possesses social capital including trust, norms, traditions, and networks that tend to be self-reinforcing in shaping people's behaviours (Putman et al., 1993a; 1993b; CSR 1997; Chimbiri 2007). The rules and norms in the society give certain institutional actors authority over others in determining their actions. Social norms give what Giddens (1979) refers to as 'authoritative resources', or the ability to define actions and priorities and enforce actions for others.

Moreover, due to marked disjuncture between some social normative ideal and modelled actual practices (Zabin and Kiragu 1995; Stewarts et al., 1998), social norms can be a cause for concern in health promotion as ambiguous norms can affect decision-making. However, empowerment that can bring social change is more likely to be effective in sexual health promotion (Friere 2000).

2.3.4 *Sexual Health and Sexual Health Promotion*

Sexual health is one the goals of the 1994 ICPD Plan of Action and remains the objective of sexual health promotion (United Nations 1995a; 1995b; UNFPA 2003; UNAIDS 2008a). Sexual health is not just about having sexual relationships. The United Nations (1995a; 1995b) defines sexual health as a broad concept involving one's physical, mental, emotional and sexual wellbeing in issue related to sexuality and sexual relationships and not merely an absence of disease or infirmity related to sexuality and reproduction. As the Ford Foundation (2005) defines sexuality as the "*ability to express one's sexuality free from the risk of sexually transmitted infections, unwanted pregnancies, coercion, violence and discrimination*" (p.18), this means that sexual health means being able to have an informed, pleasurable and safe sex life based on a positive approach to human sexuality and mutual respect in sexual relations (ibid.).

On the other hand, reproductive health "*as a state of complete physical, mental, and social wellbeing, and not just merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes*" (United Nations 1995a:40). On the other hand, "*sexual health means that people should be able to have safe and satisfying sex lives*" (UNFPA undated: 3). Sexual health has a communal aspect which can influence people's sexual behaviours (Robinson et al 2001). This is evident in several

studies that show that sexual behaviours and therefore sexual health is influenced by many determinants including social traditions and culture (Zabin and Kiragu 1995; Caldwell et al., 1998; Adamchak et al., 2000; Munthali et al., 2004; Mbugua 2007; Chimbiri 2007) in most societies. Moreover, constructions of sexual health problems vary from the scientific and social model of sexual health (CSR 1997; Stewarts et al., 1998; Kaler 2004; Munthali et al., 2004). These studies show that while early pregnancies and STIs are health problems, some cultures consider them as a badge of social achievement (ibid.). Thus, the biomedical definition of sexual health is sometimes contrary to the social definition of sexual health in some societies and this can affect sexual health promotion.

In line with Ottawa Charter for Health Promotion (WHO 1986) and the definition of SRH, Winn (1996:68) defines sexual health promotion as "*the holistic process of enabling individuals and communities to increase their control over the determinants of their sexual health, and thereby managing and improving it throughout their lifetime*". The United Nations (1995a:40) describes SRH promotion as "*the constellation of methods, techniques and services that contribute to SRH and well-being through preventing and solving SRH problems as well as enhancement of life and personal relations and not merely counseling and care related to reproduction*".

Sexual and reproductive health promotion encompasses behaviours essential for countering STIs including HIV/AIDS and unwanted or unplanned pregnancies (UNFPA undated). It encompasses many tasks performed in primary care such as provision of contraception, condoms and safer sex advice, psychological counseling and other aspects of mental health care; secondary care such as seeking treatment for STIs, and tertiary care to restore sexual activity (Curtis et al., 1995). SRH promotion also includes promotion of gender equality, SRH rights and empowerment in sexual matters. In adolescents, SRH promotion also recognises the role of families and communities besides the health facilities (United Nations 1994). Thus, ASRH promotion has a social perspective which should challenge the social norms and values that undermine people's autonomy to control over their SRH.

As such, the WHO (2001a) emphasises "*the integration of physical, emotional, intellectual and social aspects of sexuality in a way that positively enriches and promotes personality, communication and love*" (p.6-7) as a way to achieve sexual health. This therefore means that sexual health promotion that focus on individualistic interventions are likely to have limitations in SRH promotion as sexual behaviours have symbolic meanings in the societies and hence people are more likely to adhere to their behaviours regardless of the threat they are associated with (Irwin 1997; Robinson et al., 2001; Lee 2007).

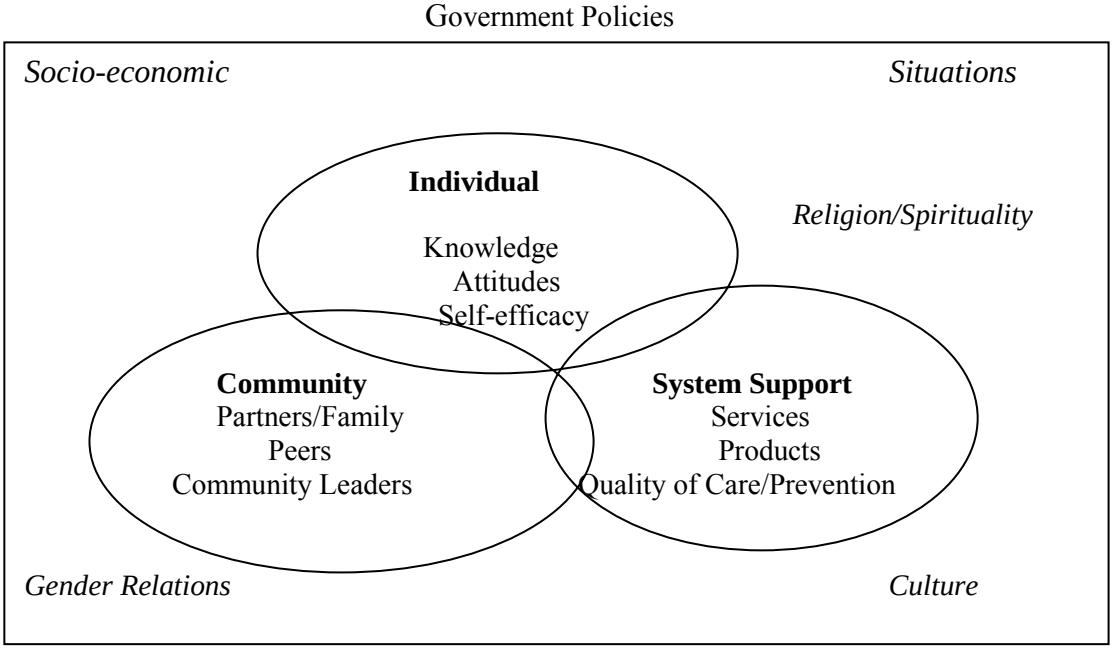
Sexual health promotion can prevent potentially unhealthy situations such as unwanted pregnancies, STIs, deviant (socially unacceptable) sexual behaviours and sexual abuse. It can also enhance individuals' quality of life by improving self-esteem, communication and relationships with family, community and sexual partners all of which are crucial for health promotion (Tones and Tilford 2001). Understanding sexuality, and not just sex, could also foster and encourage the development of self-esteem, confidence, self-control and good relationships throughout one's life and this can improve sexual health (Options for Sexual Health 2008).

Because of the moral values associated with sexuality, health promotion interventions may face challenges to succeed if such moral issues are not taken into account in the health promotion programmes (Mustakova-Possardt 2003). Moreover, as ASRH determinants are multiple (Adamchak, et al., 2000), this means sexual health promotion should aim to empower the community and individuals to control the determinants of health and to make healthy sexual health choices (WHO 1986a; Curtis, et al., 1995). In this respect therefore, placing sexual health promotion within wider social, political and cultural contexts and aiming to eliminate the cultural constructions of sexuality that increase the risk of males or females to SRH problems through the elimination of the influences of homosociality, stigma or gender differences could be essential in an effort to promote sexual health (Irwin 1997). Such conceptualisations of sexual health promotion informed an understanding of adolescent reproductive health promotion programming in Malawi.

2.3.5 *Adolescent Sexual Health Promotion Framework in Malawi*

In Malawi, ASRH promotion is based on the National AIDS Commission (NAC) and Ministry of Health (MoH) framework (NAC and MoH 2003) for behaviour change. Like the social model of health (Dahlgren and Whitehead 1991), the Malawi Behaviour Change Intervention Strategy (NAC and MoH 2003) recognises intersection of individual, socio-economic, cultural factors and government policies as being crucial in influencing behaviour change (Figure 2.3).

Figure 2.3: Determinants of Sexual Behaviour Change in Malawi



Source: NAC and MoH 2003:16

From the above framework, it is obvious that the social and cultural norms informed and defined by the gender relations, culture, religion/spirituality and other social norms affect individuals, communities and system support in their agency to promote sexual health in Malawi (NAC 2003a). Besides, several individual, community and system level factors influence individuals to adopt or not to adopt safe sex practices. As such, health promotion that does not consider the wider social context in which adolescents live may be ineffective in sexual health promotion (ibid.).

While some initiatives have attempted to use the framework in developing their interventions (e.g. BRIDGE 2004; Save the Children 2002; 2004), reviews of such programmes reveal frequent deficiencies in the capacity of the approach to empower people to control ASRH. For instance, while the framework recognises the importance of social and cultural context which several programmes targeted through community mobilisation (Save the Children 2002; BRIDGE 2004; Malawi Government 1999; NAC and MoH 2003), all programmes failed to transform the social norms which influence sexual behaviours (NAC 2003a; 2003b). By not transforming the social norms, most institutions indirectly reinforced the moral and cultural values which could increase adolescents' vulnerability to ASRH problems (Montfort Press undated; Byamugisha 2000; Munthali et al., 2004; Save the Children 2004) as illustrated

> It is clear that at least up to the appearance of AIDS epidemic, the churches had made little or no impact against the traditions that encourage promiscuity in Africa. … Most of the Church leaders never even discussed the looming disaster in their respective churches. … As a result many young people find their parents and teachers ill-equipped or afraid to teach them about sexual issues (Shorter and Onyacha 1998:41, 51, 98).

Moreover, while sex and AIDS education was introduced in schools in primary and secondary schools in Malawi since 1994 (UNESCO, MIE and UNFPA 1998), the content of such education emphasises moral-based interventions that promote abstinence only among young people (Kadzamira et al., 2001). This makes young people not to be well equipped with knowledge and skills about the alternative options of sex practices that can be used to promote their sexual health especially if they are disinclined to abstain from sex. However, evidence reveals that social norms associated with identities constrain the institutions from changing their norms (Shorter and Onyacha 1998; Byamugisha 2000). Moreover, because of Kamuzu Banda's reign who forced people to maintain their ties with their socio-cultural past as well as to respect the influence of missionaries on sexual issues (Putter 2003), social and religious norms constrained people to use the norms as the basis of their behaviours. Their access to western beliefs was restricted and hence any western ideologies of adolescent sexual health were resisted by the communities. This therefore became a significant factor in determining the nature of response to western ideologies of sexual health promotion. In this context, social identities associated with adolescence and institutions could challenge the effectiveness of health promotion.

2.4 *Challenges of Adolescence to Sexual Health Promotion*

The notion of adolescence poses a great challenge to health promotion in Malawi. As the social construction of adolescence is not homogenous, this implies that heterogenous groups of adolescents within one society may require different health promotion initiatives to ensure that they address the needs of different groups. Thus, having one type of intervention for various groups can render health promotion interventions ineffective (Nutbeam et al., 1993; Mitchell 1994).

Moreover, as socialisation of young people in Malawi is informed by the western culture-through the schools, religion and other western media, and the traditional culture-through initiation rites and other traditional institutions, adolescents acquire ambiguous sexual culture which can affect their sex behaviours. Thus, the western sexual message - you can have responsible sex (UNFPA 2003) and the traditional message - no premarital sex at all (Hickey 1997); are contradictory. Because of the community's disapproval of the western ideologies of ASRH promotion, this could make the societies not to support the modern health promotion interventions.

Furthermore, ambiguous and contradictory traditional messages - no premarital sex - alongside other traditions like initiation rituals encouraging sexual activity within one society can confuse adolescents in their decision-making regarding SRH. All together, the ambiguity and contradictions in sexual culture can make it difficult to design a health promotion initiative that can be successful as the different cultures can be confusing to adolescents' behaviours apart from lack of support to some programmes.

Additionally, as the construction of adolescence is attached to the concept of social representation/identities (Moscovici 1981; 1984), this could also be a source of resistance for communities to accept and support interventions that aim to change the social norms unless if the society is transformed.

Lastly, because the meanings and values of sexual behaviours vary across societies as well within societies, this might imply that health promotion interventions that do not

address the varying determinants of different groups of adolescents within or across the societies may be ineffective in ASRH promotion (Lloyd et al., 1997). For instance, if the cause of adopting unsafe sex practices is poverty, health promotion intervention cannot influence behaviour change unless if other determinants of the sex practices are addressed. Thus, precursors for adopting unsafe sex practices should be met first.

2.5 ***Conclusion***

Overall, the social construction of adolescence is associated with social identities that can put adolescents' SRH at risk. The variations in the meanings of adolescence and associated social identities across social contexts mean that determinants of the adolescents' sexual and reproductive practices may vary considerably and hence effective programmes and interventions need to be designed to take that diversity into account (UNDP et al., 2002). As such, understandings of the social construction of adolescence are critical for effective ASRH promotion efforts. Thus, understanding of cultural construction of adolescence based on social context rather than World Health Organisation's biological definition as well as conceptualisation of health and health promotion would inform the further development of suitable and appropriate policies and programmes with adolescents. Therefore, the following chapter reviews the approaches used to promote ASRH.

Chapter Three

Overview of Approaches Used in Addressing Adolescent Sexual and Reproductive Health

3.0 *Introduction*

Over the past decade there has been growing awareness of the need to make health services more accessible, available and responsive to the specific needs of young people in order to empower them to control their SRH (United Nations 1995a; 1995b; WHO 2003a; 2003b). The alarming rates of SRH problems among young people have contributed to this increasing attention. Today millions of adolescents face many SRH risks including unwanted pregnancy, abortions and STIs including HIV/AIDS (WHO 1993b; UNFPA 2003; UNAIDS 2004; 2006; UNAIDS and WHO 2004; 2006).

While several factors have been attributed to the increased rates of ASRH problems (UNFPA 2003), literature in the sub-Sahara Africa is full of evidence of the role of social and cultural norms that influence the incidences of ASRH problems (Acholla-Ayayo 1997). These norms include traditions related to initiation rituals that promote sexual intercourse as a sign of maturity to adulthood and to demonstrate their virility (Kornifield and Namate 1997; Kibbe 1999); early initiation of sex (Nedi et al., 2002; AGI 2005b), early marriages (Noble et al., 1996; Kishor and Neitzel 1996), gender-based violence (Oheneba-Sakyi and Takyi 1997; Wolff et al., 2000; Dreze and Murthi 2001; Walker and Gilbert 2002; Mesfin 2002) and sexual harassment and rape (Noble et al., 1996; Sebunya 1996; Adepoju 1997; WHO 200b); while in some African countries, about two million girls undergo harmful health practices such as female genital mutilation each year as part of socialisation (UNFPA 2003). These norms increase young people's vulnerability to SRH problems particularly HIV/AIDS.

Recognising the threat adolescents' face, the 1994 ICPD came up with recommendations to introduce ASRH services that would address the determinants of SRH among adolescents (United Nations 1995a; 1995b). Despite the various efforts to address SRH needs of adolescents in order to reduce their SRH problems, evidence in various countries shows that ASRH problems are still increasing (UNFPA 2003). This chapter therefore

provides an overview of approaches that have been used to address the ASRH needs. The review builds on literature on evaluation studies on adolescent SRH services that have been carried out. I used a broad search strategy, covering several separate electronic databases, including PubMed, EBOHOST, MedLine and Popline. Search terms used included “adolescent SRH” or “youth SRH” or “young people’s SRH” and “developing countries” or “resource poor settings” or “poor countries” or “sub-Sahara Africa” or “culturally-conservative/sensitive societies”. Other key words included “adolescent friendly reproductive health services” or “youth-friendly reproductive health services” or “adolescent sexual or reproductive health”.

As the study aimed to assess the capacity of YFRHS, only studies that provide the impact of the intervention on young people's access to services were used. Moreover, studies whose primary aim was to assess factors associated with young people's adoption of safe sex practices and not only to increase knowledge were used. Evidence shows that increase in knowledge on its own does not translate into behaviour change (NAC 2003). Furthermore, studies which focused on the impact of social norms on young people’s, community members’ and health workers’ agency for health promotion were included. The inclusion criteria allowed the researcher to have a broader understanding of various factors associated with ASRH behaviours.

Most of the articles were acquired online from Queen Margaret University and Edinburgh University Libraries. Personal contacts were also made with researchers who have studied adolescent health programmes and projects in developing countries in order to identify unpublished reports of ASRH project evaluations. The literature review focused primarily on articles and reports written in English.

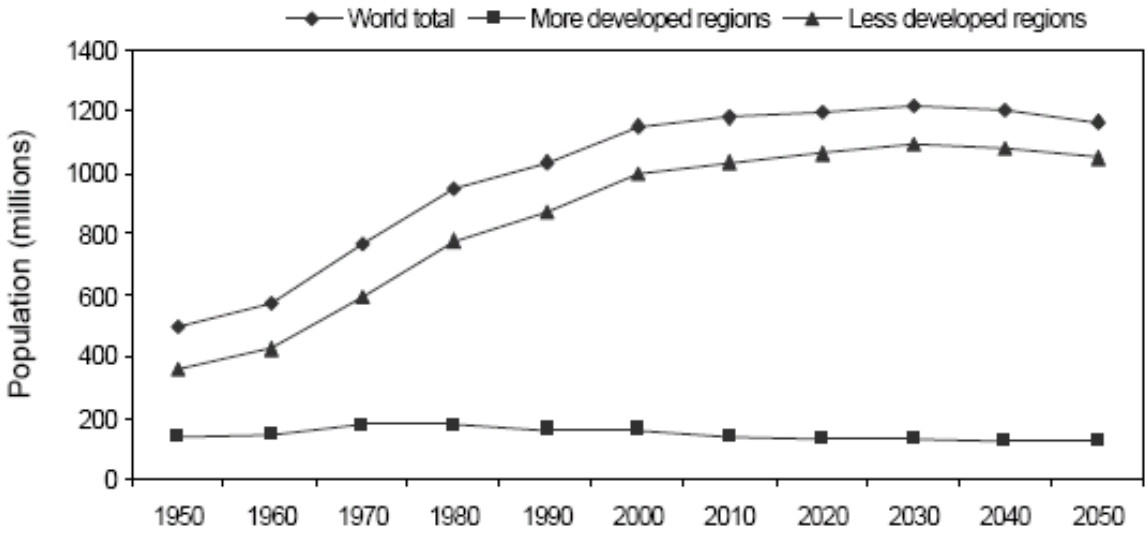
The chapter begins by presenting an overview of adolescent demographics. The second section presents an epidemiological overview of ASRH situation. The third section examines the role of social and cultural norms in ASRH. The fourth section provides an overview of ASRH strategies that have been implemented. The chapter concludes that while diverse SRH strategies have been implemented, they are not effective enough to transform the cultural and social norms that shape adolescent sexual practices in societies

where culture influence people's behaviours (Zabin and Kiragu 1995; Chirwa 1998; Chirwa and Kudzala 2001). Social norms continue to encourage adolescents to engage in unsafe sex practices. This therefore means that a research undertaken to understand the role and processes underlying the social norms in ASRH promotion is important.

3.1 ***Demographic Transition of Adolescents***

The world today has the largest group of adolescents in history, with 1.2 billion persons aged 10-19; and thus making up 20 percent of the world's population (AGI 1995a; United Nations 1999; WHO 2002a; UNFPA 2003). This sub-population comprises a large portion of the world population. Majority of adolescents (85 percent) live in developing countries (UNFPA 1997; United Nations 1999). About 16% of those living in the developing countries live in Africa (UNICEF 2001). Although the overall trends of adolescent populations have been growing till the year 2000 in both developed and developing countries as compared to the total world population, the projected trends of adolescents from 2000 are stabilising in both developed and developing countries (Figure 3.1).

Figure 3.1*: World Population of Adolescents, 1950–2050 (Medium Fertility Scenario)*

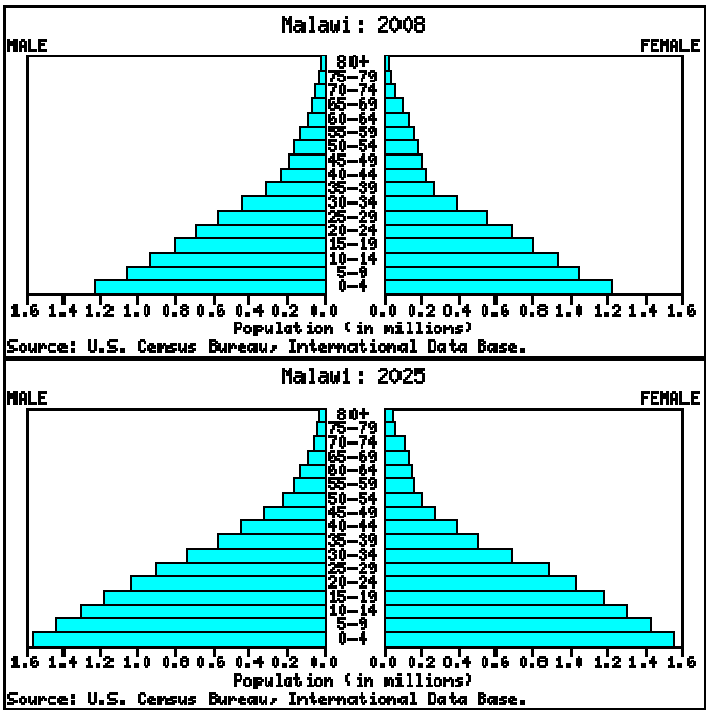


Source: United Nations (Department of Economic and Social Affairs, Population Division) (1999)

While the adolescent population growth rate is stabilising, the numbers of adolescents are massive such that SRH problems facing them could have negative effects on social and economic developments (UNFPA 2003).

Similarly, Malawi like many African countries (United States Census Bureau 2005) has a broad-based population pyramid where adolescents (10-19 years) constitute a large proportion of the total population (NSO 2005; AGI 2005a). The 2008 US Census Bureau report shows that adolescents in Malawi comprise the largest portion of the population and further projection shows that the trend will continue for sometime (US Census Bureau 2008) (see Figure 3.2).

Figure 3.2: *Population Pyramids-Malawi*



Source: US Census Bureau, Population Division 2008

These population pyramids mean that the projected adolescent population in Malawi will be growing over the time. This adolescent population growth means that millions of adolescents will be soon entering their sexually active and potentially child-bearing years (UNFPA 1998). However, without access to SRH information and services due to cultural norms or any other reasons restricting adolescents' access to SRH services or information, many adolescents are likely to be exposed to SRH problems with time. This implies that

there will be increased levels of disability-adjusted life year (DALY) (a measure of overall disease burden) associated with ASRH problems (Havelaar 2007). Thus, because of the adolescent population growth rate, the demographic impact of SRH among adolescent will be higher (i.e. more illnesses, more deaths and increased DALY if ASRH issues are not tackled) (Havelaar 2007). Besides, the increased adolescent population exposed to SRH problems would require health resources to tackle ASRH problems and their impact on individual, population and national developments will be high and this is likely to have impact on social and economic development of Malawi (UNFPA 2003). To health policy-makers and planners, this could mean allocating the scarce recourses to address the SRH needs of adolescents especially in the developing countries which could pose an enormous challenge (WHO 2003b; UNFPA 2003).

Moreover, some reports indicate that more young women are reaching puberty earlier and, in some countries entering into marriage later (PRB and Centre for Population Options 1994; AGI 1998). As a result, a significant number of adolescents of childbearing age around the world are sexually active and an increasing proportion of sexual activity is occurring outside of marriage (PRB and Centre for Population Options 1994). For instance, surveys show that about 43% and 20% of 20-year-old women in sub-Saharan Africa and Latin America respectively have had premarital sex (AGI 1998). Despite this sexual activity, a recent study of 14 countries throughout the world shows that sexual intercourse among the never-married young people appears to be very sporadic and probably involves a number of partners over time and often have unprotected sex (Singh et al. 2000). This sub-population also has problems to access SRH services for several reasons (Senderowitz 1999; UNFPA 2003).

These demographics mean that increased number of adolescents coupled by difficulties in accessing SRH services has potential to increase adolescents' vulnerability to SRH problems. However, evidence from some studies has revealed that actions taken during adolescence are likely to influence a person's life opportunities and future healthy pattern (UNFPA 2003; WHO 2004). This means that unless other interventions are done, more adolescents are likely to have SRH problems which may affect social and economic development of Malawi. Additionally, this large population of adolescents could also

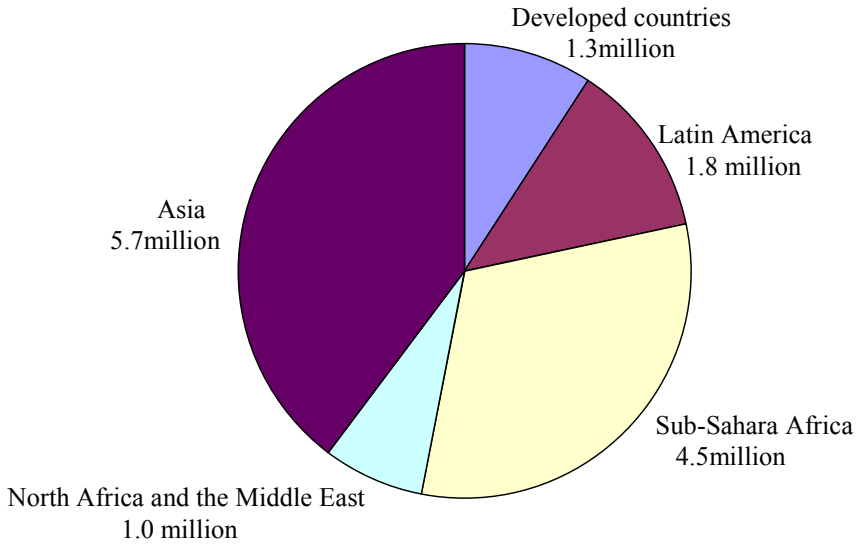
mean that there will be increased rates of ASRH problems which would demand increased resource allocations from governments to prevent or treat such problems. All these can hinder national development.

3.2 ***An Epidemiological Overview of ASRH Status***

3.2.1*Adolescent Pregnancies*

Globally, about 15 million adolescents aged 15 to 19 years give birth, accounting for up to one-fifth of all births (UNFPA 1997). Most of the adolescent childbearing happens in the developing countries (Figure 3.3).

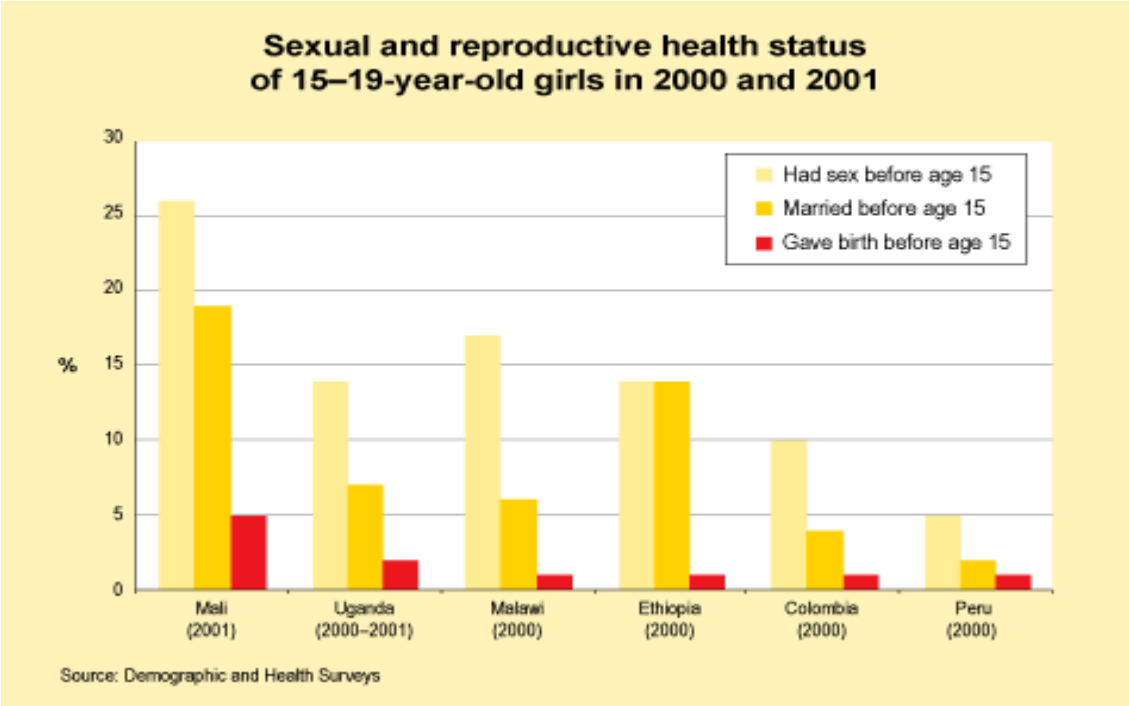
Figure 3.3: *Births to Adolescent Women each year, by Region (total 14 million)*



Source: Alan Guttmacher Institute 1998

According to the United Nations (1996), the level of adolescent fertility in least developed countries is twice as high as that in developing countries and four times higher than that in the developed countries. It is estimated that about 40% of women in the developing countries give birth before the age of twenty years, ranging from a low of 8 percent in East Asia to a high of 56 percent in West Africa (Noble et al. 1996). These early pregnancies make young women in developing countries more likely than adult women to experience complications or die from childbirth (IPPF 1994). Other evidence however shows that social norms that promote early sexual debut, early marriages and early childbearing are common and might contribute to the trend of ASRH status (Figure 3.4).

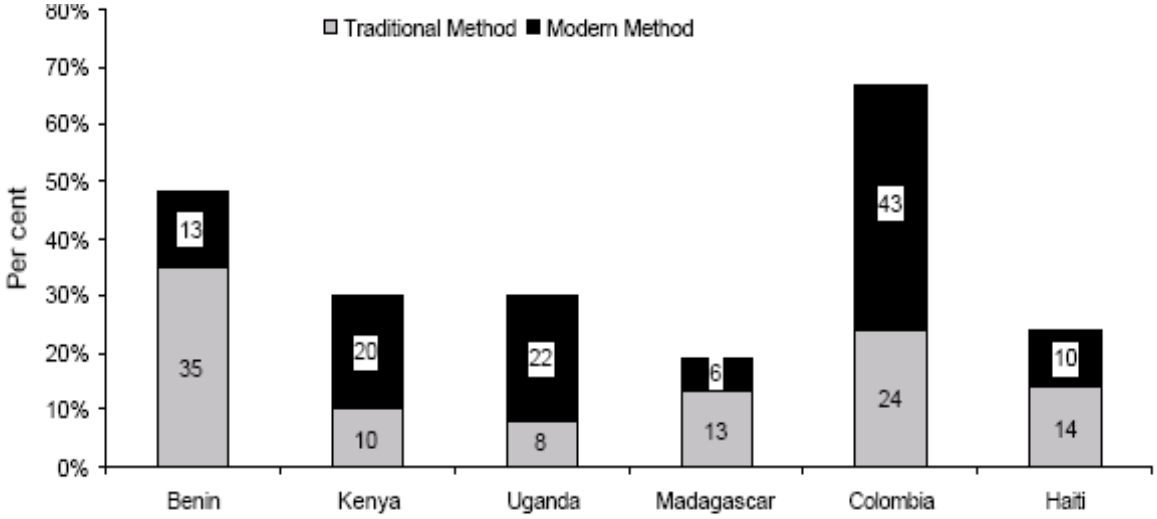
Figure 3.4: *Common Social Practices that Can Affect ASRH Status of 15-year-old girls in 2000/01*



Source: UNAIDS 2004

Statistics also indicates that approximately 60% of pregnancies and births to adolescents in developing countries are unintended compared to only about 10% of adolescents in many developed regions (ICRW 1996). Although out-of-wedlock pregnancies are undesirable in most societies as young women who become pregnant may face disapproval from the community and pregnant students are expelled from schools (Zabin and Kiragu 1998), the use of modern contraceptives among the unmarried adolescents is low in most developing countries (Figure3.5).

Figure 3.5: *Contraceptive use among single, sexually active 15–19 year-old women- Selected Studies*



Source: Population Reference Bureau 2000

This means that the prevalence of early and unplanned pregnancies is likely to rise in the developing countries. However, due to lack of access to SRH services, they often seek abortion to avoid being expelled from school (Zabin and Kiragu 1998) and it is stated that teenagers are over-represented among those obtaining abortion and even more so among those needing medical care for complications of unsafe abortion (UNFPA 1997). It is estimated that up to 4.4 million adolescents in developing countries undergo unsafe abortion each year (PRB and Centre for Population Options 1994; Noble et al. 1996; UNAIDS 1997). In countries where abortion is illegal or restricted by age, young women may be forced to have septic abortions (Pathfinder International 1998b; Koontz and Conly 1994). These septic abortions may result in complications and hence may contribute to a high proportion of the maternal deaths among adolescents age 15 to 19 years (ibid.).

However, this trend may be exacerbated by some social values in some developing countries. In most sub-Sahara African countries for instance, pregnancies raise the social status of girls in the society and in some societies young women are encouraged to have early marriages in order to have children (Zabin and Kiragu 1995; Caldwell et al., 1998; Phiri 1997). UNAIDS (2004) also noted that due to cultural pressure, most young people become sexually active in their teens, and many before their fifteenth birthday.

Moreover, increased urbanization that leads to exposure to conflicting ideas about sexual values and behaviour and the breakdown of traditional sexuality and reproduction information channels encourage premarital sexual activity among adolescents (ibid.). This could imply that any initiatives aiming to reduce teen pregnancies is more likely to fail if the social system promoting early childbearing is not addressed.

3.2.2 *Sexually Transmitted Infections and HIV/AIDS*

According to the World Health Organisation, there are 333 million new cases of STIs that occur every year worldwide (WHO/UNFPA/UNICEF 1999). However, the incidence of STIs is disproportionately high among young people. Statistics show that at least 111 million of the new cases occur in young people under the age 25 years (ibid.). The highest rates of STIs, including HIV, are found among young people age 20 to 24; while the next highest rate occurs among adolescents aged 15 to 19 years (Noble et al. 1996; UNAIDS 1999a; 2002a; 2002b; 2003c). Statistics also indicate that each year, one out of every twenty adolescents contracts an STI, some of which can cause lifelong health problems like infertility if left untreated (Noble et al., 1996). UNFPA (2003) estimates that everyday more than a quarter of a million young people become infected with an STI. Each year, up to 100 million adolescents ages 15-19 years become infected with curable STIs (UNAIDS 1997). The rates of STIs are also highest among 15-19 years age group in some African countries (UNAIDS 1997). Surveys in sexually active adolescents under 19 years of age for instance, revealed STI prevalence rates of 23% in antenatal clinics, 41% in MCH/FP clinics and 33% in young school people (Maggwa and Ngugi 1992).

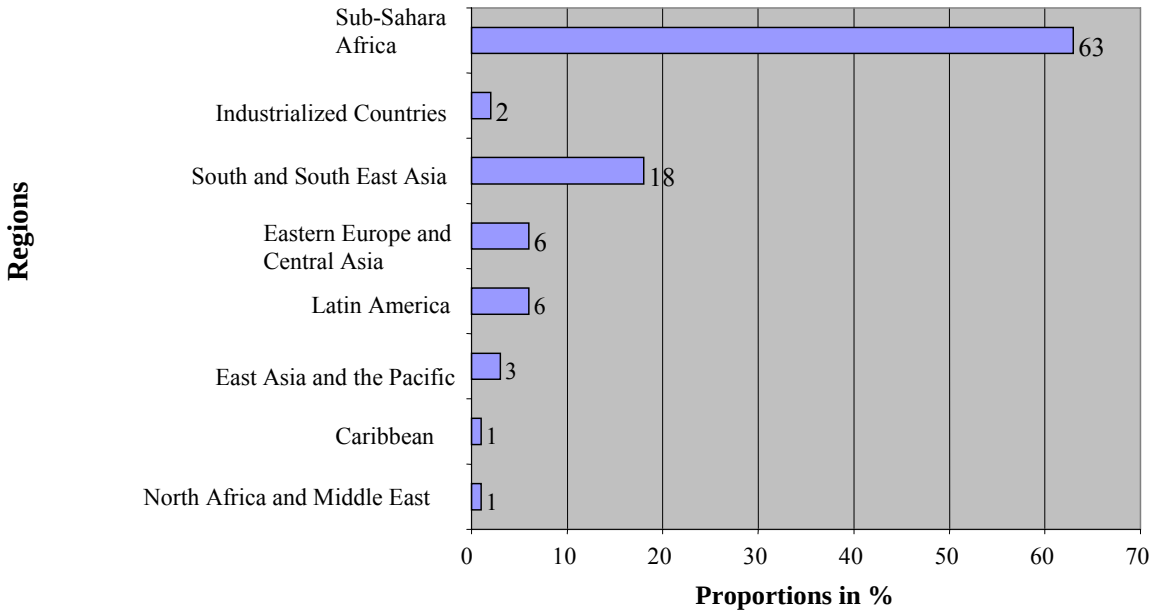
Like other STIs, HIV/AIDS remains a global health problem of unprecedented dimensions (UNAIDS 2008a). It has already caused an estimated 25 million deaths worldwide and has generated profound demographic changes in most heavily affected countries (ibid.). Statistics suggest that HIV/AIDS is becoming the infections of young people (UNFPA 2003; UNAIDS 2008a). Statistics shows that more than 10 million of the people currently living with HIV/AIDS are between the ages 15 and 24 years. Globally, nearly half of all new HIV infections occur in young people less than 25 years and up to 60% of all new HIV infections occur among 15 – 24 year olds each year (ibid.).

However, recent statistics indicate that the global percentage of adults living with HIV has levelled off since 2000. Unlike in the previous years, there were 2.7million new HIV infections and 2 million HIV-related deaths in 2007 (ibid.). Similarly, in some countries in Asia, Latin America and Sub-Sahara Africa, the annual number of new infections is falling. In some countries, the declines in the HIV prevalence exceeded 25% (UNAIDS 2008a). HIV prevalence among young people (15-24 years) in the most affected countries including in the SSA countries has also declined since 2000-2001 (ibid.).

Although HIV prevalence is stabilising globally, HIV prevalence rates in the Sub-Sahara Africa are still high (compare HIV prevalence rates of different regions – UNAIDS 2008a). Moreover, unlike in other regions of the world, the sub-Saharan region is the most affected region by the HIV pandemic. Two-thirds (67%) of the global total of 33 million (30-35 million) people with HIV live in this region and three-quarters (75%) of all AIDS deaths in 2007 occurred there (UNAIDS 2008a). According to the 20008 UNAIDS Report, SSA's epidemics vary significantly from country to country in both scale and scope. Statistics indicate that adult national HIV prevalence is below 2% in several countries of West and Central Africa as well as in the horn of Africa, but in 2007 it exceeded 15% in seven southern African countries- Botswana, Namibia, Lesotho, Swaziland, South Africa, Zambia and Zimbabwe and was above 5% in seven other countries mostly in the Central and East Africa – Cameroon, Central African Republic, Gabon, Malawi, Mozambique, Uganda and Tanzania (UNAIDS 2008a). Moreover, among the 44 African countries scored, all but four have generalised epidemics (UNAIDS and WHO 2003; UNAIDS 2008a). Furthermore, an estimated 1.9 million (1.6-21 million) people were newly infected with HIV in SSA in 2007, bringing to 22 million (20.5-23.6 million) the number of people living with HIV in the region (UNAIDS 2008a).

The prevalence of HIV/AIDS among the youth is also high in the region. Of the 11.8 million young people living with HIV/AIDS world-wide, about 8.6 million are young people age 15 – 24 years and almost 3 million children under 15 years living with HIV live in the sub-Saharan Africa (UNAIDS and WHO 2002; UNICEF, UNAIDS and WHO 2002; UNICEF/UNAIDS 2004; UNAIDS 2008a) – see Figure 3.6.

Figure 3.6: *Young People (15-24 Years) Living with HIV/AIDS by Region, end 2003*



Source: UNICEF/UNAIDS 2004

Statistics also indicate that of the approximately 2.5 million youth who are newly infected with HIV every year, Africa takes the greatest brunt with 1.8 million young people infected every year, whereas the corresponding figure in Asia and Pacific is 700,000 (UNAIDS 1998). Other data suggest that there are over 7,000 new infections per day among those15 to 24 years old in the Sub-Saharan Africa (UNAIDS 1997; 1998) while other data in some countries suggest that approximately 50% of HIV infections occur before the age of 20 years (loveLife undated). However, evidence shows that about two-thirds of the newly infected adolescents age 15-19 are females (UNAIDS and WHO 2001; PRB 2003; Pisani 2003; UNAIDS 2004; Nelson Mandela Foundation 2005). This significant gender difference in HIV prevalence points to an urgent need to challenge social norms regarding existing and dominant conceptualisations of sexuality, femininity and masculinity that compromise their control over sexual issues.

Recent statistics however show that most epidemics in the SSA appear to have stabilised, although often at very high levels particularly in Southern Africa; and in a growing number of countries, adult HIV prevalence appears to be falling (UNAIDS 2008a). In

many southern African countries, HIV data suggest that the epidemic is stabilising (MoHP [Malawi] 2005; MoH [Zambia] 2005; Michelo et al., 2006; MoH [Botswana] 2006; Kirungi et al., 2006; MoH [Uganda] and ORC Macro 2006; Uganda Bureau of Statistics and Macro International Inc 2007; MoH and Child Welfare [Zimbabwe] 2007; NAC [Malawi] 2007). In some countries like Malawi and Zambia, the epidemics appear to have stabilised amid some evidence of favourable behaviour changes (Heaton et al., 2006; Sandoy et al., 2007). On the contrary, in some countries like Lesotho and parts of Mozambique, HIV prevalence among young people (15-24 years) is increasing (Conselho Nacional de Combate ao HIV/SIDA 2006; UNAIDS 2008a).

Despite the declines in HIV prevalence rates in most of the SSA countries (see also Asamoah-Odei et al., 2004; Federal MoH [Nigeria] 2006), sub-Sahara remains the region mostly heavily affected by HIV, accounting for 67% of all people living with HIV and for 75% of all AIDS deaths in 2007 (UNAIDS 2008a). There are also signs of a possible resurgence in sexual risk-taking that could cause the epidemic to grow again (ibid.). For instance, while the pattern of sexual behaviours among young people is improving, national surveys between 1990 and 2007 indicate that the percentage of both young men and women (15-19 years) who become sexually active before their fifteenth birthday declined in some countries, it has increased in other countries (UNAIDS 2008a). The 2008 UNAIDS report also shows variations in the extent of the adoption of safe sex practices by countries or sex (ibid.). However, several recent studies suggest that culture that can increase the vulnerability of adolescents to STIs including HIV/AIDS is the norm and still common in most SSA societies (Letamo 2003; Kaler 2003; 2004; Chege 2005; Chimbiri 2007; Mbugua 2007). This means that culture is also likely to worsen HIV epidemic because it would continue to expose young people to sexual behaviours that might increase HIV transmission.

Like other countries in the sub-Saharan countries, Malawi is experiencing significant HIV epidemics. HIV/AIDS epidemic has been on the increase over the past decade and its impact is now manifested in Malawi. The number of people estimated to be living with HIV has risen from 2001 t0 2007 – see Table 3.1 (UNAIDS 2008b).

Table 3.1: Estimated Number of Adults and Children Living with HIV in Malawi

Age category	*Number of People living with HIV in 2001*	*Number of People living with HIV in 2001*
Adults (15+ yrs) and Children	850,000	930,000
Adults (15 + yrs)	780,000	840,000
Children (0-14 yrs)	65,000	91,000
Adults (15-49 yrs) (in %)	13.3%	11.9%
Women (15+ yrs)	440,000	490,000

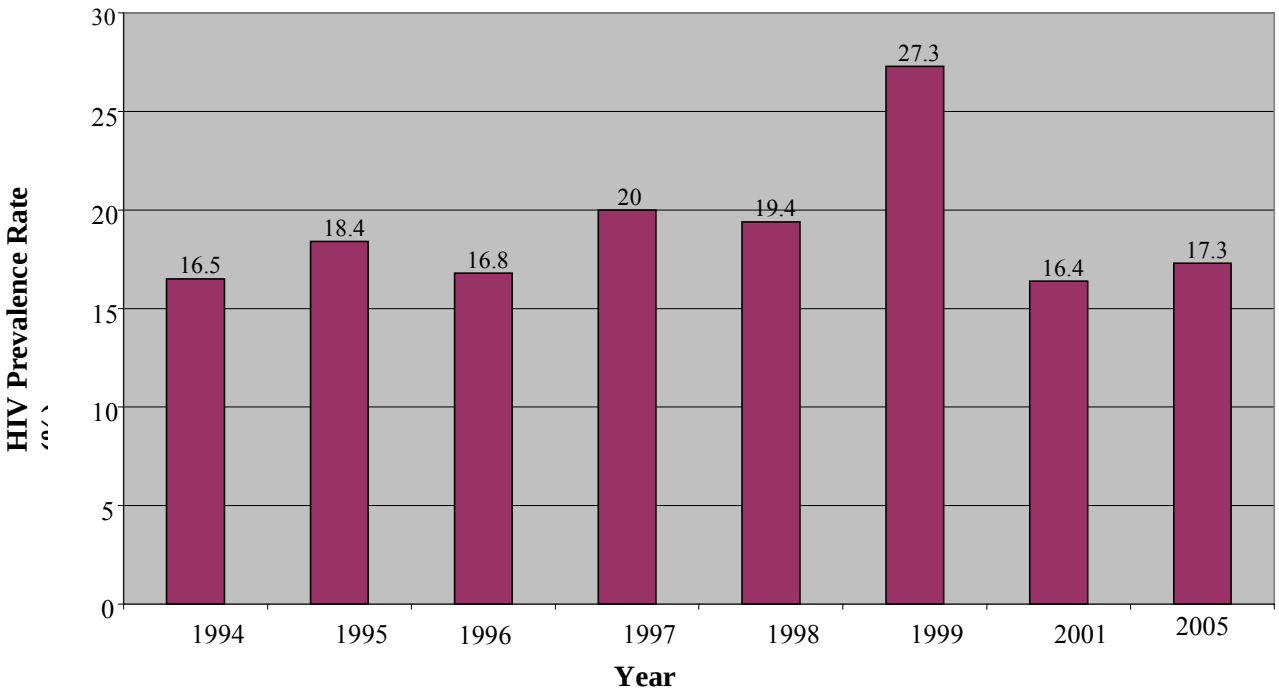
Source: UNAIDS 2008b

Recent statistics also indicate that out of a population of nearly 14 million, almost one million people in Malawi were living with HIV at the end of 2007 (UNAIDS 2008b). HIV/AIDS has also caused over 650,000 deaths, continues to be responsible for the majority of deaths in Malawi (UNAIDS 2008b; WHO 2005; The Chronicle 2005; Reuter NewsMedia 2005; UNAIDS 2002) and is a major factor in the country's low life expectancy of just 43 years (MoHP 2004; NAC 2007a; 2007b). Other UNAIDS reports also suggest that 70% of hospital deaths in Malawi are currently AIDS related (UNAIDS 2008b; 2002).

While the estimated percentage of adults aged 15-49 years living with HIV was 1.1% globally and 7.5% in SSA, it reached 14.2% in Malawi at the end of 2003 (UNAIDS 2004), the Malawi national HIV prevalence has now stabilised between 11% and 17% since the mid-90s (NAC 2003; UNAIDS 2008b). The HIV prevalence rates among young people was estimated to be over 15% (NAC 2003). The prevalence among women attending antenatal clinics has however fallen slightly (UNAIDS 2008b). While several urban areas like Lilongwe have witnessed a decline in HIV prevalence, some rural areas have seen prevalence increase (Bello, Chipeta and Aberle-Grasse 2006). Moreover, the HIV prevalence rate in Mangochi District, the study site, is higher than the national HIV prevalence rate as it is estimated to be 17.3% in 2005 (UNAIDS 2008b). The trend of HIV prevalence in Mangochi however shows that HIV prevalence rates have been fluctuating -

rising over the period from 1994 to 1999 and declined in 2001 (16.4%) and risen again in 2005 (17.3) (ibid.). See figure below

Figure 3.7 : HIV Surveillance Prevalence in Mangochi District (1994-2005)



Source: UNAIDS 2008b

Although HIV infect people of all ages in Malawi, HIV prevalence among young people is increasing. The majority of HIV infection occurs among young people particularly those between the ages 13 and 24 years (UNAIDS 2008b). For instance, unlike the national HIV prevalence, HIV prevalence rates among young (15-24 years) pregnant women in the capital city of Malawi was 18.0% in 2003 (UNAIDS 2004). Moreover, while a national population-based survey showed that while HIV prevalence rates among male young people and female young people (15-24 years) were 2.1% and 9.1% respectively in 2004, a 2007 report showed that the prevalence rates among male young people and female young people were 2.4% and 8.4% respectively (UNAIDS 2008b). However, other statistics shows that among 15-19 year age group, HIV affects more than four times as many females as males (WHO 2005). This is also reflected in national prevalence that shows that the prevalence rate is higher amongst females than males- around 60% of adults (15-49 years) living with HIV infections in Malawi are females

(UNAIDS 2008b). Other studies in Malawi attribute the increased prevalence among young people to cultural norms like death cleansing rituals and structural gender asymmetry that increase females' vulnerability to HIV infections (Kornifield and Namate 1997; Munthali et al., 2004; CRH 2005). All these mean that STIs including HIV/AIDS are and will continue to be a major health issue among adolescents in Malawi.

However, other reports show that the rates of HIV/AIDS may be underestimated due to methodological limitations in most African countries (WHO 2001a; 2002c; UNAIDS and WHO 2003). Firstly, as most HIV estimates are mainly antenatal clinic-based, the high-risk adolescents who may be using contraceptives other than condoms may not be captured as they may not become pregnant. Further, pregnant women who may not be attending clinics for one reason or another may also be missed out.

Secondly, because the sentinel surveillance sites are usually located in urban or semi-urban areas, data from people from the rural areas may not be captured (UNAIDS and WHO 2003).

Lastly, lack of male participants in the sentinel surveillance samples may also bias the results as males may also have their own ways which may predispose them to HIV infection like drug injections, homosexuality and frequent emigration to other countries where they may also have sexual contacts that are not tested in the males' countries of residence. In this case, the use of antenatal clinic mothers as proxy of HIV rates may underestimate the prevalence rates in the country as data for such high risk groups may not be captured (ibid.).

While several factors are associated with increased rates of STIs including HIV/AIDS (UNFPA 2003), evidence from developing countries reveals that social norms influence adolescent sex practices that can increase adolescents' vulnerability. These include the social and cultural system that perpetuates an ambiguous culture and stigmatisation of sexual issues among young people (Munthali et al., 2004; Rankin et al., 2005a; Holzemer et al, 2007; Dlamini et al., 2007). Examples of such ambiguous culture include restriction on SRH education to young people while at the same time promoting traditions that

encourage early sexual activity or early marriages (Hickey 1997; Caldwell et al., 1998; WHO 2000). Besides, other norms that undermine young people' autonomy can also make it difficult for them to control their sexual health (WHO 2001b; UNAIDS 2004). The above evidence surely points to the importance of understanding the role of culture in ASRH promotion.

3.3 ***Culture, Empowerment and ASRH Promotion***

Although most studies on YFRHS and adolescent sexual behaviours have concentrated on the importance of quality of health services (Chirwa 1998; Zeko and Weiss 1998; Senderowitz 1999), the above review suggest the importance of social and cultural factors in ASRH. Kristin et al., (2000) also argued that modifications of health services alone without consideration of cultural context in which adolescent sex practices occur may not be effective in ASRH promotion. Culture and social traditions related to sexuality appear to play a vital role in influencing sexual and reproductive behaviours among adolescents in societies where culture define the norm of living (Caldwell et al., 1998; Airhihenbuwa and De Witt Webster 2004; Leclerc-Madlala 2002a; 2002b). Due to the influence of cultural norms, adoption of unsafe sex practices including unprotected sex and early pregnancies among unmarried adolescents is not only quite normal; it is strongly encouraged, reinforced and desired by culture (Kiragu and Zabin 1995; Stewarts et al., 1998; Caldwell et al., 1998; Munthali et al., 2004; Chege 2005; Mbugua 2007). Apparently, the community's approval and acceptance of the norms and community's desire to maintain social reputation and identity prevent them from providing comprehensive sex education to unmarried people (Chirwa and Kudzala 2001; Chege 2005; Mbugua 2007).

Mazrui (1986:239) defines culture as '*a system of interrelated values active enough to influence and condition perception, judgement, communication, and behaviour in certain society*'. Several writers have postulated the role of culture in health, health behaviours and health care practices in a society (Brody 1987; Lupton 1994; Hahn 1995). In most societies, culture is generally considered as the foundation on which health behaviour is expressed and through which health must be defined and understood (Airhihenbuwa and De Witt Webster 2004). Cultural and social norms are woven into interpretations and

expressions of health and health behaviours through dynamic and interactive relationships at all levels of influence in the society (Caldwell et al., 1998). At the individual and group levels, cultural norms have a substantial role in influencing health-related behaviours while cultural differences can also affect the responsiveness of the diverse populations to health care system. At the national levels, cultural norms may inform the formation of health policies and programmes (Caldwell et al., 1998; Chimbiri 2002; 2007). As such, a critical understanding of the roles of culture in ASRH promotion is imperative.

Cultures can directly or indirectly influence ASRH due to presence of some norms that may promote sexual activity or promote male power control and female subservience in sexual matters.

3.3.1 *Cultural Norms Promoting Sexual Activity*

Some traditions promote sexual practices that can increase young people's risk to SRH problems. These include initiation rites, cultural cleansing (CSR 1997; Munthali et al., 2004) and use of sexual intercourse with young girls or virgins as a cure of STIs including HIV/AIDS (Leclerc-Madlala 2002a; 2002b; Lema 1997; Tengia-Kessy 1998; Mbugua 1997; Noble et al., 1996; Sebunya 1996; Argent et al., 1995; Adepoju 1997). Furthermore, because some risky sexual practices such as unprotected sex, early marriages, having multiple sexual partners or early sexual debut are tolerated in most African countries, as they raise social status of young people (CSR 1997; Finger 1997; Caldwell et al., 1998; Macleod 1999; Kaler 2004), adolescents are encouraged to adopt the unsafe sexual behaviours (Hickey 1997; CSR 1997; Palamuleni 2002; Kaler 2004). In a way, such culture limits the young people's agency to carry out health promoting activity (Nedi et al., 2002).

Additionally, other traditions that promote early sex practices and early marriages are relatively common in most sub-Saharan countries (Mati 1989; Noble et al., 1996; Kishor and Neitzel 1996; Meekers and Calves 1997) In other societies, young women are taken as co-wives after puberty while young boys are allowed to have sex with their brothers' or fathers' younger wives (Caldwell et a., 1998). Because of this, sexual initiation occurs early usually between 11-15 years (Nedi et al., 2002; Munthali et al., 2004; Zabin and

Kiragu 1995; Caldwell et al., 1998). Furthermore, because some sexual relationships like early marriages often occur between young girls and considerably older men who might have other sexual partners (Sharif 1993; AGI 1995), the young girls in such relationships may not have the power to negotiate for safe sex (AGI 1995). As such, such relationships can increase the girls' level of risk to SRH problems. Besides these practices may have SRH consequences as non-consensual sex might result in early and unplanned pregnancy, abortions or STI/HIV infections because people involved are less likely to use protective measures like condoms (Jejeebhhoy and Bott 2003).

In most sub-Sahara African societies, use of coercion by males is a normal practice in sexual relationships (Wood and Jewkes 1997; Njovana and Watts 1996). Besides, in some countries, girls are subjected to female genital mutilation (FGM) (AGI 1998; Pathfinder International 2000). However, because unprotected sex is practised in most of these sexual encounters or unsterile procedures are used during FGM, such traditions can increase the risk of SRH problems including early pregnancies and STIs and HIV/AIDS (Kibbe 1999; Kornifield and Namate 1997).

Literature also shows ambiguities in the social norms related to sex practices that can confuse adolescents' SRH decision-making in most societies. For instance, while most traditions in the sub-Sahara Africa prohibit premarital sex, the same societies also have some traditions like initiation rituals that promote early sexual activity (Kiragu and Zabin 1995; CSR 1997; Caldwell et al., 1998). Thus, while one culture prohibits premarital sex, the same culture promotes unsafe premarital sexual activity as a sign of transition to maturity (CSR 1997). Similarly, while pregnancies to unmarried adolescents are virtually deemed immoral in most African countries, (Murcot 1980; Kulin 1988; Barker and Rich 1992; Geronimus 1991; Macleod 2003; Kidger 2005), the same culture teaches the importance of childbearing to young girls (CSR 1997; Caldwell et al., 1998). In this way, cultural norms that encourage sexual activity at early ages, tolerate risky sexual practices or have ambiguous norms can disempower adolescents from carrying out SRH promoting activities.

3.3.2 *Culture Promoting Male Control and Female Subservience in SRH*

In most African societies, cultural shaping of young people's sexuality gives privileges for males to be sexually active, be in control of sexual relationships and be less responsible for precautions to prevent SRH problems (Taffa et al., 2002). Females on the other hand, are socially expected to be submissive and their socialisation denies them to develop the skills and self-confidence needed to negotiate for safe sex practices (Kim 2001; Fekadu 2001). The dominance of males over females with regard to SRH control has been documented particularly in many developing countries (Seeley et al., 1993b; Standing 1997, WHO 1998a; Connell 2000; Chimbiri 2002; Ervo and Johansson 2003; Ruxton 2004). These gender inequalities have profound implications for SRH promotion among adolescents. The females' lack of control in SRH issues as well as inability to negotiate for safe sex practices could compound their risk to SRH problems (Barbeiri 1993; Oheneba-Sakyi and Takyi 1997; Wolff et al., 2000; Dreze and Murthi 2001; Walker and Gilbert 2002; Mesfin 2002; WHO 2002b). In addition, the male dominance in SRH issues can also limit female adolescents' utilisation of SRH services as they would need approval from their male partners before they adopt some SRH behaviours that can protect their sexual health (WHO 1998a; Chimbiri 2002; UNFPA 2003).

Male control and female subservience can also affect adolescents' agency for health promotion. Adolescents, especially girls, are vulnerable to sexual violence, coerced sex due to unequal power in heterosexual relationships (WHO 2002b). As a result of the female powerlessness and fear of being beaten by their male partners, females engage in some unsafe sex practices that could increase their vulnerability to SRH problems. For instance, due to male preference for sex with females with 'dry' vaginas, use of traditional vaginal stimulants is common in some societies like in Zambia, Zaire and Uganda (Standing and Kisekka 1989; Bledsoe 1991). This could increase the potential for abrasions during intercourse that may further increase the risk of HIV transmission. However, as such unsafe male behaviours are tolerated and sometimes even encouraged in some societies (Finger 2000), these gender imbalances could increase adolescents' risk of having SRH problems as such sexual encounters rarely use protective measures like condoms (Kim 2001). Thus, cultural norms that promote gender inequalities can disempower some adolescents from adopting safe SRH preventive measures.

3.3.3 *Culture as Obstacle to SRH Service Use*

Most societies have norms about expected sexual behaviours for unmarried adolescents. These norms act as social control to people's behaviours in the society in order to discourage young people to become sexually immoral (Goffman 1963; Alonzo Reynolds 1995; Harvey 2001). However, literature shows that some forms of social control like stigma may hinder adolescents from accessing SRH services and counseling. Certain behaviours which are stigmatised can cause adolescents to be socially isolated, discriminated, rejected or lose their self-worth (Holzemer et al, 2007). Thus, stigma can make people with socially-perceived deviant behaviours being discriminated in the society (Rankin et al., 2005a; 2005b). The discrimination which can be self, social or institutional as well as loss of self-worth can hinder some adolescents from seeking health care, receive social support or even participate in self-care (Fife and Wight 2000; Varas-Diaz et al, 2005; Rankin et al, 2005a; 2005b; Holzemer et al, 2007; Dlamini et al, 2007).

In some societies, provision of SRH information to young people has been challenging because sexual issues involve matters of great cultural sensitivity (Senderowitz 2000). In some societies, provision of SRH services to unmarried adolescents is equated to promoting premarital sex which is a taboo (Chirwa and Kudzala 2001; Mbugua 2007). Because of this, many societies customarily withhold SRH information from unmarried adolescents till it is felt necessary to give it, which usually happens following puberty or marriage (Senderowitz 2000). Some social values also restrict parents' involvement in providing sex education and instead only allow traditional counselors to provide sex and SRH information to young people although parents spend most of the time with their children (Kroger 1998). This however denies adolescents easy access to sex and SRH information that could empower them for SRH promotion (Irwin et al, 1994).

While health workers could be an alternative source of sex and SRH information, several studies show that the cultural background of the health workers also influences their role in ASRH promotion. Most health workers promote the cultural norms at the expense of the ASRH promotion especially if the health promotion activities are against their own culture (Trevarthen 1988; Vygotsky 1986; Rogoff 1990; Ortner 2004). Thus, due to some cultural norms that promote abstinence only among unmarried adolescents, SRH

provision to this group has been fraught with greater concerns about promoting premarital sexual activity (Senderowitz 2000; Chirwa and Kudzala 2001). Such attitudes make people including health workers to believe that unmarried adolescents do not require SRH services. Because of this, efforts to provide SRH services to young people in most countries are targeted at pregnant or parenting young people probably because they have already commenced sexual activity (Senderowitz 2000) and because they have obvious needs that could lead to poor health outcomes if they could not be met (UNFPA 2003).

Overall, culture disempowers adolescents, communities and health workers to carry out activities that could promote SRH in unmarried adolescents. As such, YFRHS should aim at changing the culture so that it can be a resource to empower the adolescents, communities and health workers for ASRH promotion. Therefore the section below provides an overview of approaches that have been used to address ASRH promotion.

3.4 ***Health Care Approaches Used in ASRH Promotion***

Several healthcare provision approaches have been used in many developing countries to promote adolescent sexual health (WHO 1978, Mayhew 1996; SADC 2003; WHO 2006a; Hardee and Yount 2008). However, the commonly used approaches in ASRH promotion are traditional health care system, western health care system and empowerment-based health promotion strategies.

3.4.1 *Traditional Health Practice and ASRH*

Traditional health care is the oldest health care system used in most societies of developing countries. It has been an essential component for SRH delivery to young people (Kiapi-Iwa and Hart 2004) and the use of traditional medicines in African countries is widespread (Zachariah et al., 2002; MacPhail et al., 2002; Sebit et al., 2000).Traditional health system is used as a primary source of health care among most people in developing countries. In some cases, western health care is used if the traditional health care is ineffective in most societies (ibid.).

The importance of the traditional health care is well documented in Africa. Despite technological developments, traditional health care system is still recognised in Africa.

For instance, in some countries like across the Southern Africa Development Community (SADC) (a community of 14 countries working towards economic, political and development growth); there exists an extensive network of traditional health providers that has an important role in health-care delivery (SADC 2003). In some African countries, up to 70% of the general population use traditional healers (UNAIDS 2002b; Zachariah et al., 2002).

Several reasons are attributed to the preference of traditional health care. Most communities trust traditional health systems since they represent the society's cultural beliefs on health and health care (Mills et al., 2005a; van Delden et al., 1993; Aarons and Beeching 1991; Koch et al., 1994; Ryan et al., 1993; Asplund and Britton 1990; Nishida and Sakamoto 1992). Moreover, their roots in the culture are deep, as is the respect in which they are held. The traditional health practitioners' holistic approach to health care combined with a rich tradition, and broad knowledge of their patients' physical and mental health histories and their family and community backgrounds, make the communities to trust them unlike the modern health professionals (Zachariah et al., 2002). Even in Uganda where progress to control HIV/AIDS epidemic has been reported, the conventional medical practitioners work in collaborations with traditional healers to address SRH problems particularly HIV/AIDS (Engle 1998). This shows the importance of traditional health care in some developing countries.

Although traditional health care is widespread and trusted by communities, traditional healthcare and healing practices conflict sharply with western biomedical health care (Kleinman 1980; 1988; Mayeno and Hirota 1994). While the modern health care uses scientific approach to promote health, traditional health care use cultural means to promote health. This however causes problems for the modern healthcare practitioners to accept the traditional health care system. Most western trained healthcare professionals for instance question the effectiveness of the traditional health care (Engle 1998). Despite that, evidence shows that the use of traditional health care is common probably due to the association of people to their cultural models of health and healing process (Castro and Marchand-Lucas 2000; Mills et al., 2005b). This might mean that unless communities

acquire critical consciousness of the etiology of ill-health, most communities are likely to patronise traditional healthcare for their SRH problems.

Moreover, the differences in the conceptualisations of health between the cultural and modern medical models lead to variations or problems in defining health problems and hence health promoting intervention (Uba 1992). This is evident in Botswana where the contradiction on the meaning of HIV/AIDS between the biomedical and traditional views affected the community's use of preventive services for the epidemic. The community's view that HIV/AIDS is a manifestation of the old 'Tswana' diseases, acquiring new virulence because of the increasing disrespect for the mores of traditional culture, or to these diseases mutating because they have 'mixed together' (Heald 2002) hinder people from using modern health care other than the traditional means. Thus, the association of ill-health to evil spirit or other causes other than the biomedical causes can discourage communities to use modern health care (Uba 1992).

Other writers also argue that people with traditional beliefs about health rather than the western health beliefs may be non-compliant to modern health care (Johnson et al., 1986; Jenkins et al., 1996) or such beliefs could pose obstacles to health care access (Mayeno and Hirota 1994; Kleinman 1980). To counter this, some writers argue that as health and healthcare seeking practice is based on cultural beliefs about health, cultural views should be integrated into the modern health care system if it is to attract people (Castro and Marchand-Lucas 2000; Piscitelli et al., 2002; SADC 2003; Mills et al., 2005b). Other researchers argue that incorporation of social dimensions of sex practices into health promotion intervention can make them more effective (Hardon 1987; Miles and Ololo 2003). Otherwise, because of the variations, achieving ASRH promotion goals may be problematic in the face of powerful conservative society opposition which can discourage adolescents from using modern healthcare. Thus, health interventions that leave out the ethnocultural perspectives may not be highly welcomed by the communities (Stimson and Donoghoe 1996; Rival et al., 1998) and this may affect their utilisation.

However, because community's norms may still influence them not to be compliant with the modern health care and yet the traditional health care may be ineffective, integration

of the traditional care alone may not be helpful. As such, health promotion could be successful if it facilitates conscientisation of adolescents and communities so that they can transform the social norms hindering their use of modern healthcare (Freire 2000).

3.4.2 *Western Influenced Health Care Approaches*

3.4.2.1 Selective Primary Health Care

While the 1994 ICPD Programme of Action calls for a comprehensive, client-oriented SRH services, Hardee and Yount (2008) argue that poor resource countries need to adopt selective PHC in SRH promotion. Selective primary health care (SPHC) is defined as a package of low-cost technical interventions that aim to tackle the main disease problems of poor countries (Cueto 2004). SPHC was initiated following the criticism that the Alma Ata's Primary Health Care (PHC) was too broad, idealistic, used less cost-effective health strategies and had unrealistic time-table (Walsh and Warren 1979). In SRH promotion, SPHC means that countries have to select those SRH services that provide the widest SRH benefits for most people taking into consideration epidemiological trends, services currently offered, client demand and resource availability (Hardee and Yount 2008). Thus, SPHC can be equated to provision of essential package of SRH services. The introduction of SPHC received support because it is considered that the best way to improve health was to fight disease based on cost-effective medical interventions (Walsh and Warren 1979). Thus, SPHC aims to create the right balance between scarcity of resources and making a right choice for using the resources (Evans et al., 1981).

Although SPHC was preferred to primary health care (PHC), it had some shortcomings for health promotion. As the approach is disease-oriented, it may not address the root causes of the diseases. For instance, due to its focus on diseases, other determinants of health such as social values may not be targeted by the health interventions (Gadomski et al., 1990).

Moreover, due to its resource-oriented approach, SPHC could not promote a holistic approach to health promotion. Instead vertical clinical health programmes such as safe motherhood, family planning, syndromic management of sexually transmitted infections

and many others received more emphasis (Ehiri and Prowse 1999; Magnussen et al., 2004). In other words, SPHC, unlike PHC is not a holistic approach to health promotion as illustrated by Magnussen and colleagues

> Meeting people's basic health needs requires addressing the underlying social, economic, and political causes of poor health (Magnusen et al., 2004:167).

Thus, SPHC ignores the broader context of the determinants of health and the values that affect equality in health (Dahlgren and Whitehead 1991; Curtis 2004) in order to be cost-effective.

Furthermore, because of developing countries' dependence on donor aid for health developments, international agencies can also influence national programmes in various ways that can affect the content of SRH services and hence meeting the health needs of the people. This is exemplified in the case of Global Gag Rule which prohibits the provision of some services like abortion (World Bank 1993; Mitchell et al., 1994) although some people may choose it as a way of preventing early childbearing. Also, because of the contentiousness of SRH promotion in unmarried adolescents, political will and motivation by high level government officials to include ASRH may be low. This can affect the content of SRH policies and hence may limit availability of some SRH services that could benefit unmarried adolescents in poor resource countries (Dixon-Mueller 1993a; Bruce 1994; Freedman 1994; WHO 2006a).

However, while SPHC programmes may leave out certain services for financial reasons or moral reasons, it may be difficult to ignore other services in SRH promotion because conditions in SRH are interrelated (Queen et al., 1991). For instance, those who are at risk of STIs may also be at risk of HIV/AIDS and early pregnancies. This means that SPHC which may be influenced by moral values might not be effective in SRH promotion. Thus, SPHC in SRH promotion contravenes the holistic approach to health which recognises that determinants of health are interconnected and interrelated (Dahlgren and Whitehead 1991).

Because SPHC approach uses a technocratic approach to determining priorities for interventions, the approach may not design interventions that may address the root causes of health. Involvement of grassroots level could also mobilise local resources to deal with

their own health problems (Askew 1991). Technocratic approach detracts from the grassroots involvement which could provide a sound basis for effective intervention (Bichmann 1988; Magnussen et al., 2004). Besides, because technocratic approach is based on scientific medical knowledge, SPHC cannot address the social norms which influence people's health behaviours. Thus, other words, unlike PHC (WHO 1978), SPHC does not promote community empowerment.

The SPHC may also neglect other segments of the population health needs especially if the population is considered as healthy. For instance, it is argued that the high burden of some conditions like HIV/AIDS among people aged 20-39 years in many developing countries, an indication of infection in adolescence, might be attributed to the neglect of HIV/AIDS prevention intervention among the adolescent population (ILO 2000). Thus, the neglect of adolescence as healthy period of life (UNFPA 2003) can result with future negative health consequences.

In conclusion, health promotion that pays attention to the broader context and life-cycle approach rather than disease-oriented approach is more likely to meet the diverse needs of adolescents including the social norms (Berman 1982) that affect their SRH. As such SPHC has no capacity to deal with health problems whose determinants are complex and sometimes beyond the medical diagnosis and scope.

3.4.2.2 Youth Friendly Reproductive Health Services

Youth-friendly reproductive health services (YFRHS) are defined as those services that are developed and provided in a way that recognizes and addresses the challenges, difficulties, and obstacles facing adolescents to access SRH services (Pathfinder International 1998b; undated; Webb 1998). YFRHS strategy is a specialized approach to service provision aimed to attract, serve, and retain adolescents as SRH clients (Finger 1997; Pathfinder International 1998b; Senderowitz 1999; 1999; 2003). This approach was drawn as one of the recommendations made at the 1994 ICPD in Cairo, Egypt after recognising that adolescents face problems to access SRH services at health facilities due to several barriers including policies, judgemental attitudes of providers and social traditions (United Nations 1995a).

In order to achieve the YFRHS goals, certain characteristics are essential to make clinic based programmes more effective. YFRHS should have:

- appropriately trained providers who can address adolescents' specific biological, psychological, and health needs;
- respect for adolescents' privacy and confidentiality;
- accessible facilities and convenient location;
- reasonably priced services;
- flexible clinic operating time for adolescents; and
- a clinic environment that feels appropriate and comfortable for all adolescent populations (Senderowitz 1997; 1999; Armstrong et al., 1999; Webb 1998) (see Table 3.1 for details).

Table 3.2: *Key Elements of Clinic-Based Youth Friendly Reproductive Health Programme*

Key Element	Issues/Obstacles
Youth Involvement	a. Adult professionals have traditionally planned and conducted programs for youth, and resist changing; b. Working with young people as partners run counter to cultural patterns in many countries; c. Dependence on young people to assume key tasks carries some risks – including high turnover, less than reliable participation, the need for supervision, and incentive and reward structure, and extra training; d. There have been few models that actively involve youth.
Community Involvement	a. Ambivalent and moralistic attitudes challenge whether community becomes involved.
Parental Involvement	a. Parents are not the traditional informants about sex; b. Parents may feel embarrassed; c. Parents, themselves, lack the knowledge, information.
Development of Protocols, Guidelines, and Standards	a. Typically, operational policies governing how providers should serve adolescents are not clearly spelled out; b. Need additional training in getting providers to comply with protocols and standards.
Selection, Training and Deployment of Providers	Issues vary according to: a. Gender of provider; b. Age of provider; c. Knowledge, reliability, and communication skills of providers
Client Recruitment	a. Adolescents do not go for fear of bad treatment by providers; b. Many hard to reach adolescents – like those out of school – do not receive any information about service sites; c. Adolescents worry about lack of privacy/confidentiality; d. Most adolescents feel services are only for married people; e. There is a challenge to reach adolescents before their sexual debut.
Building a "Youth-Friendly" Environment	Centre should: a. Be open in the afternoons, evening, and weekends; b. Offer many RH services, including STI treatment; c. Be easily accessible, affordable, confidential, private, and staffed with sensitive service providers; d . Be designed "not to look like a clinic;" e. Be comfortable and useful for young men; f. Adolescents lack encouragement/education to know when to use clinics.

Source: Pathfinder International (undated)

Thus, YFRHS aim at improving the organisation, provision and quality of SRH services so that they should attract young people. The significance of improved quality of SRH services on service use among young people is also well documented. For instance, YFRHS has been associated with improved SRH practices among the youth like increased attendance to SRH clinics, increased utilisation of contraception, reduced number of sexual partners, increased condom use, reduced STIs and improved sexual partners communication on SRH issues among the youth (Antunes et al., 1997; Stanton et al., 1998; Fawole et al., 1999; Fitzgerald et al., 1999; Coplan et al., 1999; UNFPA 2003). Good care attracts, satisfies and keeps clients by offering them the services, supplies, information and emotional support they need to meet their reproductive and sexual needs (Vera 1993; Sealza 1994; WHO 1996; Koenig et al., 1997) while poor care could discourage young people from seeking SRH services (Bruce 1990; Yinger 1998).

However, other evidence shows that despite availability of YFRHS, some traditions can hinder the impact of such services. For instance, in Thailand where there are no legal restrictions to serving young unmarried adolescents, young people are reported to be reluctant to use public health facilities for reproductive healthcare because they fear health workers' judgemental attitudes influenced by their disapproval of premarital sexual activity (Nare et al., 1996). In Malawi also, some YFRHS providers were found to refuse to provide SRH services to young people due to religious reasons (Chirwa and Kudzala 2001).

Moreover, although staffs' technical competence is part of YFRHS and crucial for attracting adolescents to use services, the definitions of quality services differ between providers' and users' views. While professional quality emphasises on efficiency, technical competence and cost-effectiveness (Wensing et al., 1994), users in some societies have their own perception of quality that is usually informed by the social norms (Chirwa and Kudzala 2001). For example, respect by health workers is seen as important element among clients. The clients' views are however an important determinant of SRH service utilisation (Population Reports 1998).

Furthermore, although YFRHS promotes rights of all adolescents regardless of age and gender to access SRH services, most traditional societies do not give freedom and rights to youth to control their health in general and SRH in particular in societies with rigid cultural norms. However, this lack of rights denies youth from making SRH decisions (Chimbiri 2002; 2007; Chege 2005).

Additionally, despite improved SRH service quality, some norms discourage young people from using SRH services that can promote ASRH (Senderowitz 2000; Chirwa and Kudzala 2001). This means that quality of services on its own cannot guarantee adoption of safe sexual practices because some norms deny other people's rights to use SRH services (Barbieri 1993).

Although YFRHS acknowledge that moralistic attitudes of communities can be an obstacle to ASRH (United Nations 1995a; NYCoM 2001; UNFPA 2003; WHO 2003a), YFRHS strategy in some countries like Malawi does not prepare health workers to deal with the social barriers of SRH promotion (NYCoM 2001; Pathfinder International 1998a). Because of this, YFRHS has no capacity to address the social determinants of adolescent SRH behaviours. As such, social norms can still influence adolescents' SRH behaviours and actions unless if there is transformation in adolescents' and communities' critical consciousness related to social norms in order to empower them for ASRH (Mustokova-Possardt 1998).

3.4.2.3 Empowerment-Based Health Promotion Strategies

Empowerment strategies have been widely used in addressing SRH problems among young people (Moody et al., 2003; Ramella and Bravo De la Cruz 2000; Wallerstein and Sanchez-Merki 1994; Wilson et al., 2006; Hutton 1992; Dixon 1993; WHO 2006b). Empowerment can be defined as the building of the capacity of individuals to make healthy choices regarding SRH. This is usually achieved by improving the self-concept (Tones and Tilford 1993). Self-concept can be described as the whole set of understandings, values and beliefs held by an individual about him/herself which can affect his/her attitudes, intentions and actions (ibid.). Self concept influences individual's self-esteem, self-regulation and control, self-efficacy, self-image and self-awareness, all

of which can influence personal agency for health promotion (McWhirter 1994). Therefore the empowerment-based strategies in ASRH aims at increasing capacity of individuals or groups to make choices or decisions that can promote the health of adolescents (WHO 1986; 1997).

Empowerment-based health interventions have been implemented in forms of sex and SRH education, social skills development, gender empowerment programmes and other participatory programmes like the Stepping Stones which aims to empower participants to increase control of their sexual and emotional relationships (Rissell 1994). These strategies emphasise raising awareness of feelings of powerlessness and power in health issues so as to motivate people to act to control their health (Valaitis 2002). Such empowerment could enable adolescents to develop positive and adaptive behaviours that could help them make decisions and manage the challenges of their lives (WHO 1994; WHO 1997; Hughes and McCauley 1998; Gage 1998).

Empowerment-based interventions have been focusing on individual and the community. Community empowerment is a social action process that promotes participation of people, organisations and communities towards the goals of increased individual and community control, political efficacy, improved quality of life and social justice (Wallerstein 1992). This process enables individuals, communities and organisations gain mastery over their lives in the context of changing their social and political environment to improve equity and quality of life (McWhirter 1994). Community empowerment may also aim to change the social norms affecting health. On the other hand, individual empowerment is a process whereby an individual is enabled to control the determinants that can affect his/her health (McWhirter 1994).

Although empowerment approaches appear to have potential in health promotion, there have been deficiencies in the way the approaches have been implemented to have a positive impact on health promotion. While empowerment strategies aim to ensure that individuals are able to control over their lives and exercise informed choice, the currently used strategies do not transform the cultural norms which are the stronger forces influencing adolescent sexual practices in most culturally conservative societies (Dynowski 1987; Population Council 1991; Abdool-Karim et al., 1992; Miuto 1993;

Turner 1994; Kirby et al., 1994; Chirwa and Kudzala 2001). Other evidences also show that while SRH education is intensified in ASRH, the knowledge may not empower adolescents to adopt safe sexual behaviours due to strong social pressures to conform to dominant sexual norms (Wight 1994; Wight and Abraham 2004; Welbourn 2002; Blake 2004). Other studies have also suggested that more didactic approaches like SRH education may not be effective in ASRH promotion where social norms may be influential (Blakey and Pullen 1991; Orme and Starkey 1999). In this case therefore, unless YFRHS use approaches that can transform the society's social norms that oppress on adolescents' freedom to adopt safe sex practices, YFRHS is more likely to fail in its promotion of ASRH in culturally-conservative societies.

3.4.3 *YFRH Services in Malawi*

Malawi like many other members of the United Nations adopted the 1994 ICPD Plan of Action (PoA) in September 1994. Since the country had already existing National Population Policy that was enacted in Parliament in March 1994, it only added components of the ICPD PoA that was not included in the existing policy (MoHP 2002). Furthermore, in response to the ICPD recommendations, the MoHP established the Reproductive Health Unit (RHU) in 1997 whose aim was to provide accessible, affordable and convenient comprehensive sexual and reproductive health services to all Malawian women, men and youth in order to enable them to attain their sexual and reproductive health goals (ibid.).

Youth-friendly reproductive health services were initiated in the late 1990s by the Malawi Government and its development partners to improve the youths' access to the SRH service (NYCOM 2001; JHPIEGO, GoM and USAID 2001). In the Malawian context, YFRHS meant provision of high quality health services that are relevant, accessible, affordable, appropriate and acceptable to the youth (NYCOM 2001). As such, the YFRHS framework in Malawi was designed with the aim of creating a friendly clinic environment as well as adolescent empowerment in SRH (Table 3.2).

Table 3.3: Criteria for YFRHS in Malawi

Element	***YFRHS Characteristics***
Service Provider	• Staff specially trained in provision of YFRHS – cheerful, non-judgemental, understanding, empathetic, open • Good communication skills and practice within her scope • Respect for youth (they should not feel offended) • Privacy • Confidentiality • Time (interaction time) • Peer Counselors
Health Facility	• Accessibility • Convenient location –within reach and provide privacy to avoid stigmatisation • Surroundings should be clean and conducive for use • Space and privacy • Adequate resources • Availability of Services
Programme Design	• Youth Involvement • Drop-in clients accepted • No overcrowding and short waiting times • Affordable fees • Publicity that is informative and reassuring to the youth • Wide range of services available • Necessary referrals available • Where possible, separate days or times for youth • Convenient operational time
Other Characteristics	• Educational materials appropriate for target groups • Group Discussions available • Alternative ways to access information, counseling and services outside formal health facility • Delay procedures that may threaten the youth e.g. Vaginal, Pelvic examinations • Recreational facilities available • Exchange visits or study tours

Source: NYCOM 2001

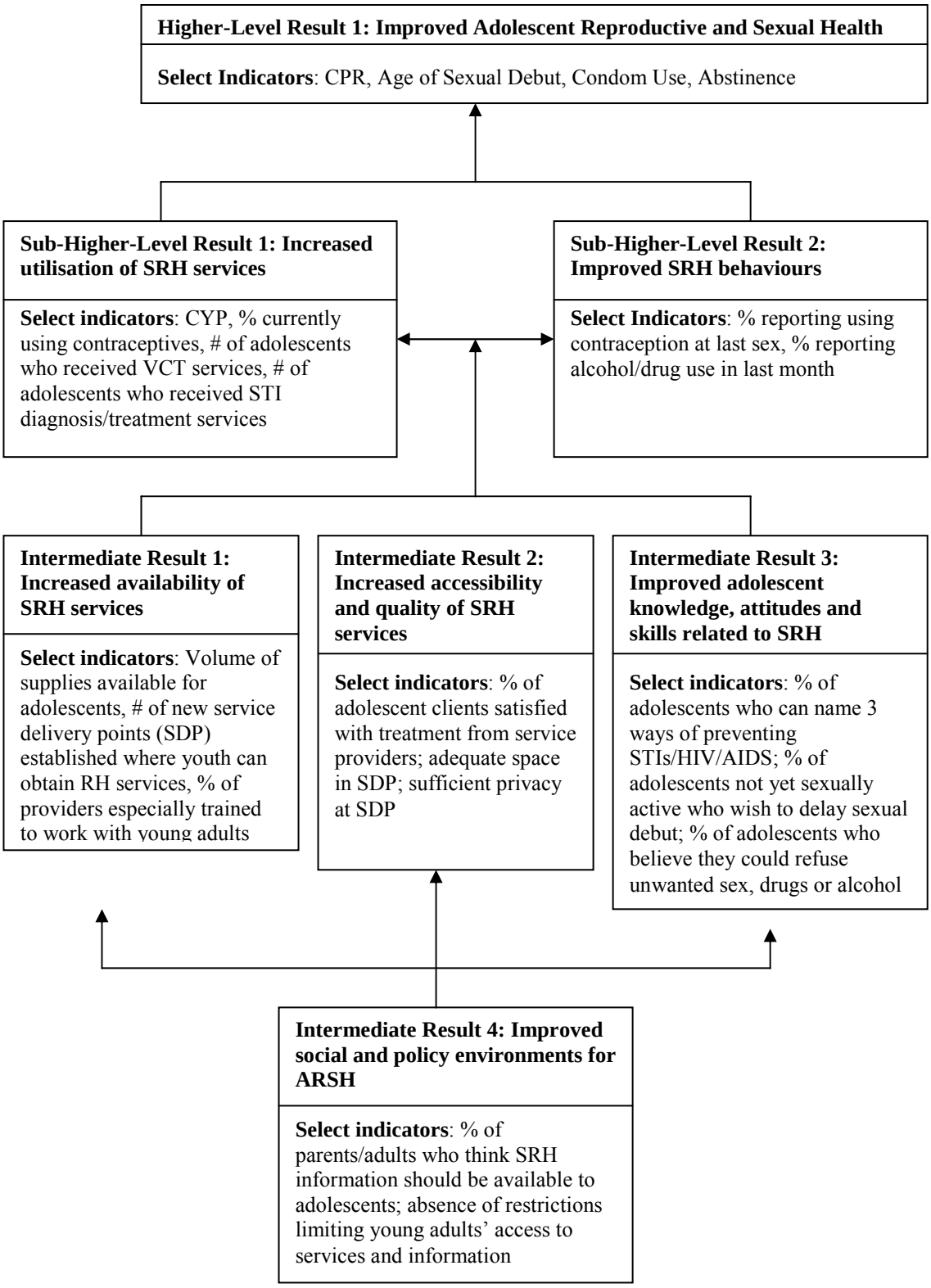
While YFRHS in Malawi also aimed to empower adolescents and communities for ARH promotion, the design's approach for empowerment could not aim to transform the social norms influencing adolescent sexual behaviours. However, the design empowered health workers though their empowerment could not enable them to become cultural change agents. This might affect YFRHS' effectiveness in ARH promotion in Malawian contexts where social norms were the main drivers of adolescent sexual behaviours.

3.4.4 *Nchanda ni Nchanda Project in Mangochi*

Nchanda ni Nchanda Pa Umi Wambone (NnN), a sub-programme of Save the Children, is a YFRH programme in Mangochi District that started in 1999 with support from the Gates Foundation. NnN is a partnership project between Mangochi District Health Office, Ministries of Education, Social Welfare and Youth, Sports and Culture and also youth community-based organisations (YCBOs), other NGOs and the communities. The project was integrated into the Ministry of Health's (MoH) SRH programme. It was initiated because adolescents in Mangochi were known to be at higher risk of SRH problems including early pregnancies and STI/HIV/AIDS due to the social and cultural practices prevalent in the district (Save the Children USA 2002).

NnN was a theory-based programme that aimed to enable and motivate adolescents to practise safe sex behaviours. The project aimed to improve the reproductive and sexual health and the overall development of youth 10-25 years of age. While several behaviour change interventions commonly used in SRH programmes including Health belief Model, Social learning theory and theory of reasoned action (Kim et al., 1998; Adamchack et al., 2000), NnN was based on a comprehensive framework that borrows key elements from a number of these theories in order to avoid being constrained by a single theoretical model. The programme is grounded on the assumption that behaviour change depends on three core components: improved SRH knowledge, attitudes and skills; improved access and availability of SRH services; and supportive social and policy environments (Save the Children USA 2002)- See Figure 3.7.

Figure 3.8: Save the Children's Adolescent Reproductive Health Framework



The framework (Figure 3.7) assumes that in order to achieve ASRH goals, there is need to have improved social and policy environments for ASRH promotion. The framework however recognises that three-pronged core activities are essential to achieve the social and policy environments: increased availability of SRH services, increased accessibility and quality of SRH services and improved knowledge, attitudes and skills related to SRH. The framework assumes that these activities could help to create an enabling and supportive environment for adolescents, health workers and communities to undertake ASRH promotion initiatives. The framework assumes that these three core activities would eventually lead to improved ASRH through increased utilisation of SRH services and adoption of other safe SRH behaviours.

In order to achieve that, both software and hardware support were also provided at the community and health facility levels. At the community level, software support included training of the gatekeepers and local people on ASRH and development, community mobilisation and sensitisation, gender issues, training of traditional initiation counselors on ASRH promotion and participatory development in order to empower them to take the lead role in ASRH promotion. The adolescents were also trained in YFRHS, peer education, community distribution of family planning commodities, gender issues, facilitation of youth club formation and life skills development. Community and individual-wide discussion on the relationships, sex and sexuality, risk, risk settings, risk behaviours and cultural practices that may include the likelihood of indulging in unsafe sex practices were held. Hardware support included construction of youth resource centres, production of youth-contributed and led newsletters, provision of transport and other logistics for exchange visits, provision of sporting materials and provision of materials for safer circumcision (Save the Children 2002).

At the policy level, NnN promoted participatory and inter-sectoral collaborations, partnerships with civil societies including religious communities, initiation counselors and traditional leaders.

At the level of the health system and health care facility, both ‘software’ and ‘hardware’ components were provided. Software support included a range of training for clinical and non-clinical staff in YFRHS. In addition, reduction of stigma, fear and discrimination, as

well as advocacy of policy and laws that could enhance ASRH promotion were considered in the programme as the prerequisite that could increase opportunities, choices and improve motivation for unmarried adolescents to practice safe sexual practices (see also FHI 2002). Hardware support ensured improved logistics for SRH commodity distribution (Save the Children 2002).

Although NnN had components that could address most determinants of adolescent sexual behaviours (Adamchak et al., 2000), there were some challenges that could affect its impact. Like in other countries (Rogoff 1990; Kiragu and Zabin 1995; Caldwell et al., 1998; Ortner 2004), social norms, resistances to change cultural practices that increased adolescents' risks to SRH problems, inconsistencies between the messages passed to adolescents during initiation rituals and the ASRH messages as well as resistance by other health workers to accept unmarried adolescents' sexual behaviours affected the success of NnN in Mangochi.

3.5 *Conclusion*

Overall, the review shows that while ASRH problems are attributed to several factors, social and cultural norms play a significant role in contributing to ASRH status. Factors such as traditions, ambiguous culture, gender roles and other social norms increase adolescents' vulnerability to SRH problems.

While several approaches have been used to promote ASRH; the existing strategies have no capacity to change these social norms-related determinants of sexual health. The review therefore suggests that there is a need to develop a health promotion strategy that can transform the communities' social consciousness towards social norms related to adolescent sexuality. However, this transformation will require an understanding of the underlying processes that drive the influences of social norms on adolescent sexual behaviours and how the processes also affect ASRH promotion. As YFRHS are at an early stage of development in Malawi, this study could inform further development of YFRHS programme. Therefore the next chapter discusses the epistemological and methodological stances used to understand the cultural determinants of adolescent sexual practices in rural Malawi and the capacity of health services to address these.

Chapter Four

Methodology and Design of the Study

4.0 *Introduction*

Researching adolescent sexual behaviours is one of the potentially difficult areas as it is open to all sorts of misunderstandings and objections (Coleman and Roker 1998). In many societies in the developing countries, sexual behaviours have ethnic and cultural values and meanings; hence adolescents may engage in such behaviour for different reasons (Zabin and Kiragu 1995; Caldwell et al., 1998; Phiri 1998; CRH 2005). Moreover, despite having norms that encourage premarital sex, there are also some social and religious norms that prohibit it among unmarried adolescents (CSR 1997; Byamugisha 2000).

Because of these cultural restrictions, researching unmarried adolescent sexual behaviours is problematic because of the sensitivity of sexual issues in most societies (Van de Wijgert et al., 2000; Mensch et al., 2001; Magnani et al., 2002b). Also, in some areas, the reasons for engaging in sexual practices are not open to the public out with the society (Chief Mponda, personal communication). Due to these factors, it could be difficult getting access to adolescents to freely talk about their private sexual lives. As such, methodologies used to investigate and understand sexual lives and practices and their determinants are important because some adolescents might find questions about sexual lives embarrassing and awkward (Roker and Coleman 1998); while some methodologies could not adequately uncover the sex practices in depth (Schutt 2001).

As the study focused on assessing the capacity of facility-based YFRHS to facilitate SRH promotion among unmarried adolescents, the study focused on four primary research questions that could help to address the research question.

- What is the status of the adoption of safe sex behaviours among unmarried adolescents in rural Malawi; and to what extent is this status associated with facility-based YFRHS?
- What factors determine unmarried adolescents' sexual and reproductive behaviours in culturally-conservative societies?
- What are the theoretical utility and limitations of YFRHS strategy among unmarried adolescents in culturally conservative societies?
- What factors affect the capacity of facility-based YFRHS to promote SRH among unmarried adolescents? How should YFRHS be conceptualised in culturally-conservative societies?

Seeking to address questions about researching sensitive subjects and in an effort to understand adolescent sex practices as they are constructed and integrated in rural Malawi, this chapter discusses the theoretical and methodological frameworks underpinning the study. The chapter begins by examining the philosophical assumptions applied in the study. The second section describes the research design. The third section describes the research setting and sampling procedures. The fourth section describes the development of the research tools. The fifth section presents the organisation of the study, while the sixth deals with data management and analysis. The seventh section describes the role of the researcher; and the chapter concludes that a research methodology informed by constructionist perspective is appropriate to understand social issues that have cultural and social meanings in the society.

4.1 ***Social Constructionist Epistemology***

Crotty defines epistemology as "*a way of understanding and explaining how we know what we know*" (Crotty 1998:3). Thus epistemology deals with the nature of knowledge, its possibility, scope and general basis (Denzin and Lincoln 1998; Hamyln, 1995). It also makes explicit the relationship assumed to be present between the knower and what is known or being sought to be known in order to ensure that knowledge generated is both adequate and legitimate (Denzin and Lincoln 2000; Maynard 1994).

As my research assumes that adolescent sex practices are informed by the social and cultural values, attitudes and beliefs in Malawi, the epistemological underpinning of this

study recognises the importance of the influence of cultural and social values as a process imbedded in the social system in which adolescent sexual behaviours occur. The study therefore adopted a social constructionist epistemology.

Social constructionist theory is an interpretive paradigm of understanding reality which posits that: "Truth, or meaning, comes into existence in and out of our engagement with the realities in our world" (Crotty 1998:8). Describing reality in a constructive way, Crotty (1998) stated

> all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and transmitted with an essentially social context (p.42).

Also commenting on the importance of social environments to individual behaviours, Holstein and (Gubrium 2003:21) stated

> Social worlds are also interactionally constructed. The statuses we acquire, the positions we occupy, and the situations in which we participate all result from what we say and do with one another (Holstein and Gubrium 2003:21).

Hirst and Wolley (1982:23) also added

> We learn about ourselves-what we experience, what we call that experience, what we think and feel about that experience-through the ways others respond to and communicate with us. Even the deepest sensations, such as so-called altered states of mind, are social matters.

Thus, social constructionism is based on shared meanings to describe, explain or account for the understandings attached to customised social beliefs, attitudes, values and actions which are communicated symbolically in a society (Gergen 2003). This approach therefore facilitated understanding of the social/cultural norms, values and beliefs in Malawian societies that influence, guide or control sexual behaviours among unmarried adolescents in their everyday lives (Crotty 1998; Robson 2002). Thus, the study acknowledges that the phenomena of adolescent sexual behaviours and their meanings are not objective but are created in human social interaction, through the process of socialisation, negotiation and renegotiation (Greenwood 1994).

Moreover, the in-depth understanding of the socio-cultural factors that influence adolescent sexual and reproductive behaviours could facilitate the designining of effective

and appropriate health interventions for adolescents rather than basing the interventions on health professionals' knowledge which cannot be effective at times as Kunitz (1990:106) clarifies

> Many health problems in both rich and poor countries are still best explained by weakly sufficient causes, or risk factors. Understanding their incidence, prevalence, and distribution, as well as their prevention and treatment, may require intimate understanding of particular people and settings. This demands a different kind of science, one based upon local knowledge, social organisation, cultural beliefs and values, and patterns of behaviour, rather than simply universal knowledge of the behaviour of viruses and GNP per capita.

In other words, other health professionals' attitudes of 'we know what is best for you' in health programming (Labonte 1989) might result in the designing of inappropriate interventions that do not address the root cause of the health problems as Armstrong (1989:3) observed

> The study… reported that people seemed to experience symptoms much more frequently than their rate of medical consultations would indicate. The researchers were surprised at this because they had assumed, as had medicine for a century and a half, that symptoms as indicators of disease almost invariably led to health seeking behaviour.

This means that using social constructionist approach would help in designing effective health promotion interventions for Malawian adolescents due to its focus on the local Malawian context (ibid.). Post-modernists also argue against universal approach to health promotion because such approach fails to take account of the unique circumstances of different societies (Hayes and Willms 1990). In this case, social constructionist approach was essential for ASRH promotion in Malawi as inadequate attention to the socio-cultural contexts and emphasis on biomedical approaches or universal approaches to ASRH could undermine the understanding of the determinants of adolescent sexual health (Armstrong 1989).

Furthermore, although some researchers argue that human behaviour is a product of rational cognitive thinking carried out by autonomous individuals who deliberately free themselves from social processes and certain values (Haste 1998; Lynch 1995), some psychologists argue that individual cognition or rationality is also a product of meanings acquired through interactions in the society (Holstein and Gubrium 2003; Hirst and

Wolley 1982). Bell (1993) and Taylor (1991) also added that people are not simply solitary beings capable of autonomous reasoning or acting from behind a veil of ignorance, or in a state of suspended objectivity from one's cultural and social context, but people are deeply social, embedded in culture, social and religious norms that may influence their thinking and actions. Mead also commented that self is only fully developed when it becomes '*an individual reflection of the general systematic pattern of social or group behaviour in which it and the others are all involved'* (Mead 1934:158).

Therefore, because the researcher appreciates the importance of the interaction between adolescents and the social contexts in the acquisition of socially constructed meanings and values of behaviours and actions related to adolescents sexual practices, social interactionism was the theoretical perspective that underpinned the understanding of the meanings and values associated with adolescent sexual behaviours and community and health workers' roles (social environments) in ASRH promotion in rural Malawi (Crotty 1998).

4.2 ***Social Interactionism***

Social interactionism is a theoretical framework that was used in the study. Crotty (1998) describes theoretical framework as the basis for understanding knowledge, scope and nature of knowledge and it provides the grounding for its logic. Theoretical perspective discusses how our understanding of knowledge fits into theoretical traditions of knowledge "*in ways that will be new, insightful, or creative*" (Marshall and Rossman 1999:35).

Social interactionism focuses on the symbolic nature of social interaction and how it conveys meanings and promotes socialisation and human actions (Crotty 1998; Schutt 2004; Jones et al., 2006). It focuses on the ways in which meanings emerge through interactions. The prime concern of social interactionism is to analyse the meanings of everyday life via close observations and intimate familiarity and from these to develop an understanding of the underlying forms of human interactions (Schutt 2004).

As social interaction is the process through which adolescents learn the traditions of the society (Mead 1934), this process influences adolescents' behaviours in several ways. First, adolescents may act to adhere to social group's norms. Second, other social norms can act as social control to adolescents' actions. In this way, social interactionism can provide an insight that can be helpful in designing effective ASRH programmes.

As the study aimed to explore the effects of social norms and values on ASRH promotion, social interactionism was appropriate considering that social and cultural contexts vary. Social interactionism aided comprehension of the social processes underlying the effects of social norms. The approach could allow grounding health interventions in ways that could address the actual determinants of adolescent sexual behaviours rather than designing the programmes based on health professionals' views of the social worlds which would likely make the interventions to miss the real cause of health problems

> The contextualisation or the grounding provided by lay perspectives allows for a perspective on behaviour which acknowledges its meaning. Behaviours which are seen from 'outside' as negative or unhealthy may be seen from within as positive and pleasure (Rogers et al., 1997:9-10).

Moreover, this approach could also help to understand the potential tensions modern health care can bring in culturally-conservative societies, as Rogers and colleagues add

> Additionally, lay accounts highlight positive or 'natural' dimensions of behaviours/lifestyles while professional perspective tends to problematise them (Rogers et al., 1997:6).

In concluding his report, Paul emphasised the importance of understanding social context from the insiders' perspective if one has to design an effective community programme

> If you wish to help a community improve its health, you must learn to think like the people of that community. Before asking a group of people to assume new health habits, it is wise to ascertain the existing habits, how these habits are linked to one another, what functions they perform, and what they mean to those who practice them (Paul 1955 cited in Scrimshaw 2001:53).

Thus, using social interactionism as the basis of understanding social issues provides new insights that can make ASRH promotion programme more effective because the approach unfolds the processes in which individuals learn, interpret, reflect and adhere to the

customised practices in their environment and act on the basis of their interpretation (Schutt 2004).

Social interactionism approach had benefits to the study. It helped to understand the ways in which people give meaning to their lives/selves, feelings, situations and indeed to the wider social worlds in ways that can affect ASRH promotion. It also helped to understand how the social world is a dynamic and dialectical web, where certain situations which can influence sexual behaviours are always encounters with unstable outcomes. Lastly, interactionism helped the study to look beneath the symbols, processes and interactions in order to determine patterns of social life. Thus, the approach sought generic social processes associated with adolescent sexuality whose understandings would help in designing effective ASRH interventions (Crotty 1998; Schutt 2004).

4.3 ***Research Design and Method***

4.3.1 *Research Methodology*

Methodology is an important part in research design. Methodology is defined as the strategy, plan of action, process or design lying behind the choice and use of particular methods and linking the choice and the use of methods to the desired outcomes (Crotty 1998). It focuses on how the researcher gains knowledge about the social world (Denzin and Lincoln 2000; Strauss and Corbin 1998; Robson 2002). As social interactionism was the basis of understanding the determinants of ASRH in this study, interpretive inquiry approach was used

> Methodologically, the implication of the symbolic interactionist perspective is that the actor's view of actions, objects, and society has to be studied seriously. The situation must be seen as the actor sees it, the meanings of objects and acts must be determined in terms of the actor's meanings, and the organisation of a course of action must be understood as the actor organises it. The role of the actor in the situation would have to be taken by the observer in order to see the social world from his perspective (Psathas 1973:6-7).

As interpretive research methods assume that people create and associate their own subjective and intersubjective meanings as they interact with the social world around them (Crotty 1998; Robson 2002; Schult 2004), the approach was appropriate for the study because it could help to understand the processes underlying the effects of social norms in

ASRH promotion through accessing the values and meanings adolescents, communities, health policy makers and health workers assign to the social norms related to adolescent sexuality. Moreover, it was invaluable as it allowed the collection of data rich in attitudes, beliefs and values associated with adolescent sex practices to be gathered which were not constrained by rigid data collecting frameworks that may have limited ability to capture cultural or social paradigms that influence adolescent sex practices (Thomson, 2003; Teram et al., 2005). This research methodology influenced the research design.

4.3.2 *Research Design*

Research design can be described as the structure of research (Robson 2002). A research design is used to structure the research, to show how all the major parts of the research project are fitted together. Thus, a design provides the glue that holds the research project together (ibid.).

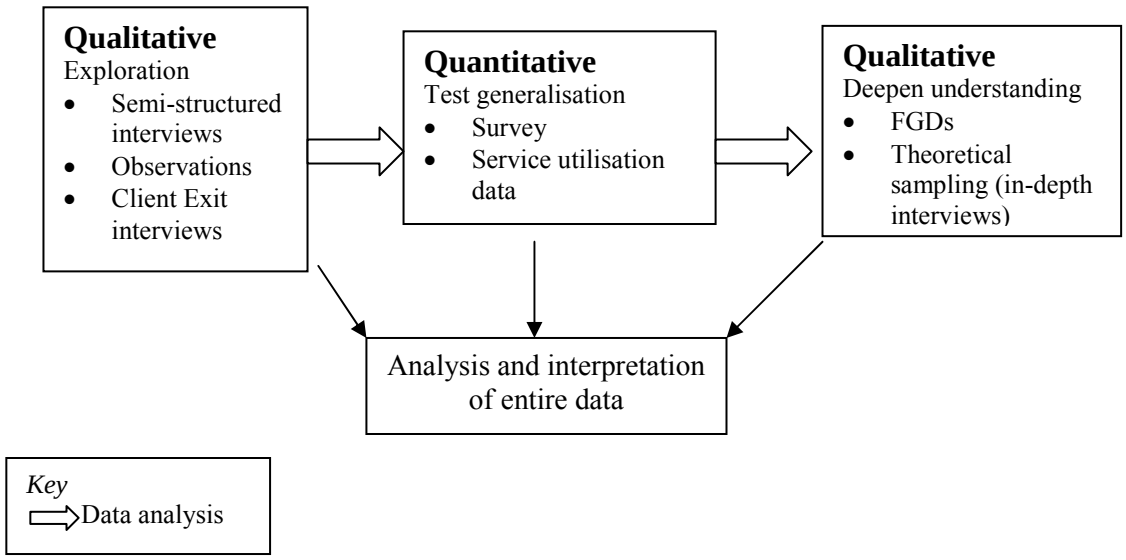
As the study aimed to assess the capacity of facility-based YFRHS, a comparative design was used. The comparison focused on the adolescent sexual behaviours between adolescents in the two study settings: intervention and non-intervention areas (see section 1.9 for definitions). In particular, the study compared the impact of facility-based YFRHS in the intervention areas and the general SRH in the non-intervention areas on influencing social norms affecting sex practices among unmarried adolescents. It also assessed how the social norms affected the functioning of the health facilities towards the promotion of SRH among unmarried adolescents.

Additionally, the study also used a sequential exploratory design in its data collection process. A sequential exploratory design is a way of enquiry whereby the initial data collection results informed the subsequent phase of the enquiry (Creswell 2003). As social interactionism was the study's theoretical perspective, the sequential exploratory approach was informed by interpretative research paradigm to assess the capacity of YFRHS on ASRH promotion (McGrath and Bedi 2002). This design was used in order to ensure social and cultural connectedness in the research instruments (Creswell 2003). Triangulation of data obtained from these various sources was a principal method by

which the reality of ASRH promotion was disentangled from the many versions of events obtained from a wide variety of sources.

The sequential exploratory design had three waves of data collection- qualitative, quantitative and qualitative data collection phases (Figure 4.1).

Figure 4.1: Sketch of Sequential Exploratory Design



The first phase used qualitative phase aimed at exploring the social norms affecting ASRH practices and ASRH promotion. The preliminary results from this phase were used to develop the survey questionnaire that was administered to unmarried adolescents in the second phase.

The second phase, quantitative phase, was used to test the elements of the emergent theory from the qualitative data from phase one. It facilitated understanding the generalisation of the qualitative findings within a target population (Creswell 1999; 2003). Service utilisation data provided an insight on the utilisation of facility services by adolescents.

The last phase (qualitative phase) used focus group discussions (FGDs) and in-depth-interviews (theoretical sampling) to deepen understanding of the major themes from the previous phase. It aimed at further clarifying, exploring and reaching a consensus on the

main emerging issues. Focus group discussions were also used as debriefing sessions for the adolescents on the findings.

The sequential exploratory design had some advantages for the study. The design improved content validity of the results as it ensured social and cultural contexts connectedness between different methods and phases of the study (Creswell 2003; Kutner, et al., 1999; Nutting et al., 2002). This design ensured the understanding of adolescent sexual practices was grounded on the local Malawian contexts (Creswell et al., 2004).

Moreover, as the design used mixed methods, it provided a thorough understanding of the adolescents' sexual behaviours through triangulation (Hammersley and Atkinson 1983; Tashakkori and Teddlie 1998). Triangulation could overcome inadequacies each research method might have in understanding the phenomenon of adolescent sex practices in Malawi (Brewer and Hunter 1989). The use of interpretive methods as the overarching research paradigm facilitated understanding of the contextual-specific and holistic explanations of the determinants of ASRH with an emphasis on the meanings (Garfinkel 2003; Miles and Huberman 1994); while quantitative methods established the distribution or patterns of the adolescent sexual behaviours (Gatrell et al., 2000; Bryan 1988). Furthermore, the flexibility of qualitative methods provided opportunities to explore new ideas and issues that had not been anticipated in planning of the study but was relevant to its purpose (AED 1995; Yates 2004).

Despite the above benefits, the design posed an operational challenge. Due to its use of multiple methods, the research required more time and resources for data collection and analysis. However, the investigator felt that such disadvantage was less important than the overall rigour the approach contributed to the understanding of YFRHS and ASRH in Malawi (Tashakkori and Teddlie 1998).

4.3.3 *Debates in Qualitative-Quantitative Mix*

Although use of mixed methods in research has been debated due to lack of congruency in philosophical positions (Lincoln and Guba 1985; Crotty 1998; Yates 2004), other researchers have argued that such classification is not exclusive as such mix could

strengthen the reliability of the research results. The mixed method approach would allow each research method's weaknesses to be overcome by the strengths of the other method as Brewer and Hunter (1989) explain

> Social science methods should not be treated as mutually exclusive alternatives among which we must choose. … Our individual methods may be flawed, but fortunately the flaws are not identical. A diversity of imperfection allows us to combine methods […] to compensate for their particular faults and imperfections (Brewer and Hunter 1989).

Moreover, research methods on their own are not fixed as being exclusively qualitative or quantitative but it is the way they are used what is likely to affect the results. Thus, if the epistemological position used for any method is right, the results of the study are likely to be valid. This is also reflected in an expression by another commentator of the quantitative-qualitative debate

> My belief is that the heart of the quantitative-qualitative debate is philosophical, not methodological (Trochim 2006:5).

Thus, combining methods is unproblematic as long as they share similar philosophical bases. Some researchers have also applauded that combining qualitative and quantitative methods could be considered as a step in the right direction to avoid dichotomy between them (Patton 1987; McPherson and Leydon 2002). Dzurec and Abraham (1993) suggested that objectives, scope, and nature of inquiry should guide the choice of research methods rather than the qualitative-quantitative method divide as Siverman (2001) recently argued

> The value of a research method should properly be gauged solely in relation to what it is trying to find out and should not be based on some empty or glossed version of what qualitative and quantitative methods mean (p.25).

In other words, the differences in epistemological stance associated with certain methods should not prevent a qualitative researcher from utilizing data collection methods more typically associated with quantitative research, and vice versa but rather the use of the methods should be based on the logic of justification of the use of the methods in the study (Bryman 1988; Howe 1988; 1992; Johnson and Onwuegbuzie 2004). However, caution should be taken because in the absence of a clear epistemology the mixed methods may result in inconsistent, ambiguous or wrong inferences and conclusions about the data as Coombes clarifies

> Even within the quantitative and qualitative camps, methods are used inappropriately and conclusions and inferences are made on spurious or ambiguous evidence. This is often the result of methods being employed by people who do not truly understand the methodology and epistemology that they originate from (Coombes 2000:29).

Overall, qualitative and quantitative methods are not exclusive in their use. However, theoretical and methodological frameworks for any research using mixed methods should be appropriate if the study has to provide reliable results as Johnson and Onwuegbuzie (2004:16) conclude "*the bottom line is that research approaches should be mixed in ways that offer the best opportunities for answering important research questions*".

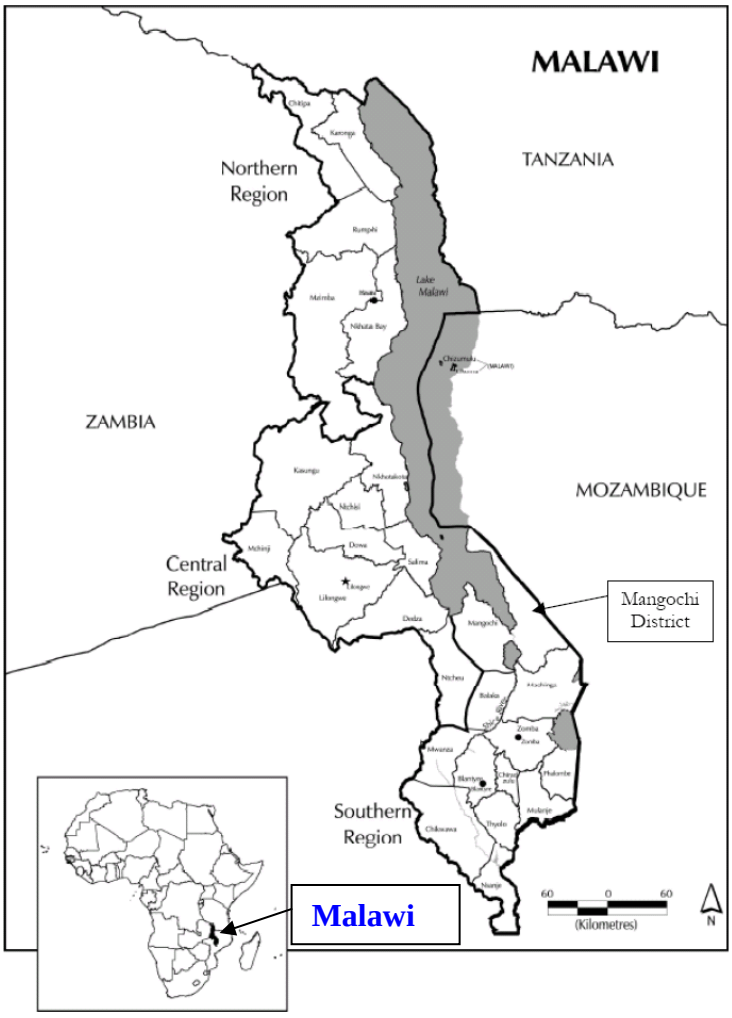
4.4 ***Research Setting and Sampling***

4.4.1 *Social Context of the Research Setting: Mangochi- Malawi*

4.4.1.1 Socio-Political Environment

The study was conducted in Mangochi in Malawi, a country with a population of 12 million (ORC and Macro 2001), situated in the south-eastern part of Africa. Mangochi is one of the districts in the Southern Region of Malawi. It is located in the eastern lakeside region of Malawi, which is 320 km from the country's capital city of Lilongwe. It lies in the southern tip of Lake Malawi where most people depend on fishing and farming for living (Figure 4.2).

Figure 4.2: *Map of Malawi Showing Mangochi District*



Mangochi District is one of the districts in Malawi which have rigid and ambiguous cultural norms. The district has several tribes but the predominant ethnic group in the district is Yao tribes which make over 90% of the population (Malawi Government 1999). The Yao are concentrated in all areas except Traditional Authorities Nankumba which has a significant presence of the Nyanjas or Chewas. Other tribes such as Ngonis, Tongas, Lomwes and Tumbukas are also found in the district (ibid.).

The people of Mangochi have maintained their traditions in a number of areas. For example, local institutions such as chieftaincy are well recognised and so are the traditional dances and initiation rites. Some people in the district still pray to ancestral

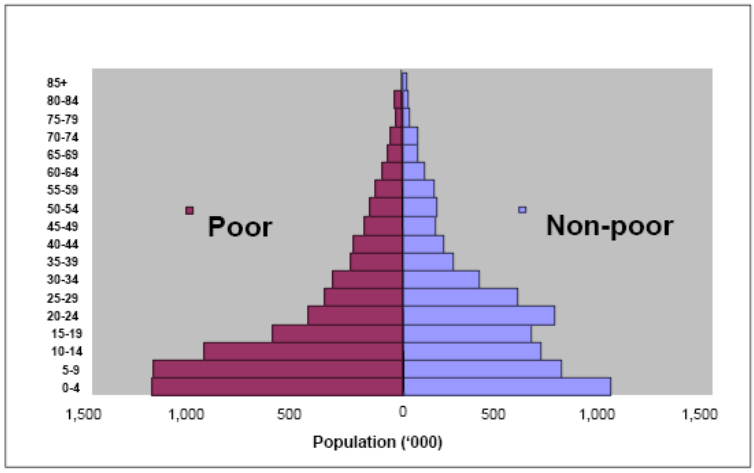
spirits in times of stress such as droughts and they maintain the family institutions (Malawi Government 1999).

Yao practise different rituals such as circumcision locally known as "*Chinamwali"* for boys (Malawi Government 1999:16). The *Chinamwali* for the Yao girls involves teachings in good manners including respect for men both in public and in their relationships (ibid.). They also have traditions including initiation ceremonies where rites of passage, cultural cleansing and other early marriage practices and many other norms that can affect ASRH occur (Malawi Government 1999; CRH 2005).

The prominent faiths in Mangochi District are Islam and Christianity, though Islam is the major religion (Malawi Government 1999). Traces of animism , that is, belief in ancestral spirits is evident during stress times such as droughts and floods (ibid.). Remarkably, culture dictates and controls people's behaviours including sexual practices (CRH 2005).This is very evident among the Yao (who are also Moslems) who resort to open rebellion (demonstration) and use of forces (fighting or burning houses or offices of people attacking their culture) if any of their cultures have been attacked or undermined by any other group of people.

Like most developing countries, Malawi has poor socioeconomic indicators. It is ranked as one of the least developed countries with a GDP per capita of US$523, the main source of economic growth being the agricultural sector (UNDP 2000). Poverty is widespread, deep and severe (ibid.). According to the Integrated Household Survey (IHS) Report, about 52% percent of Malawi's 12 million people live below poverty line of a dollar per day (NSO 2005). A wide gap exists between the rich and the poor. Moreover, statistics indicate that a remarkable proportion of adolescent population is poor (NSO 2005) (Figure 4.3).

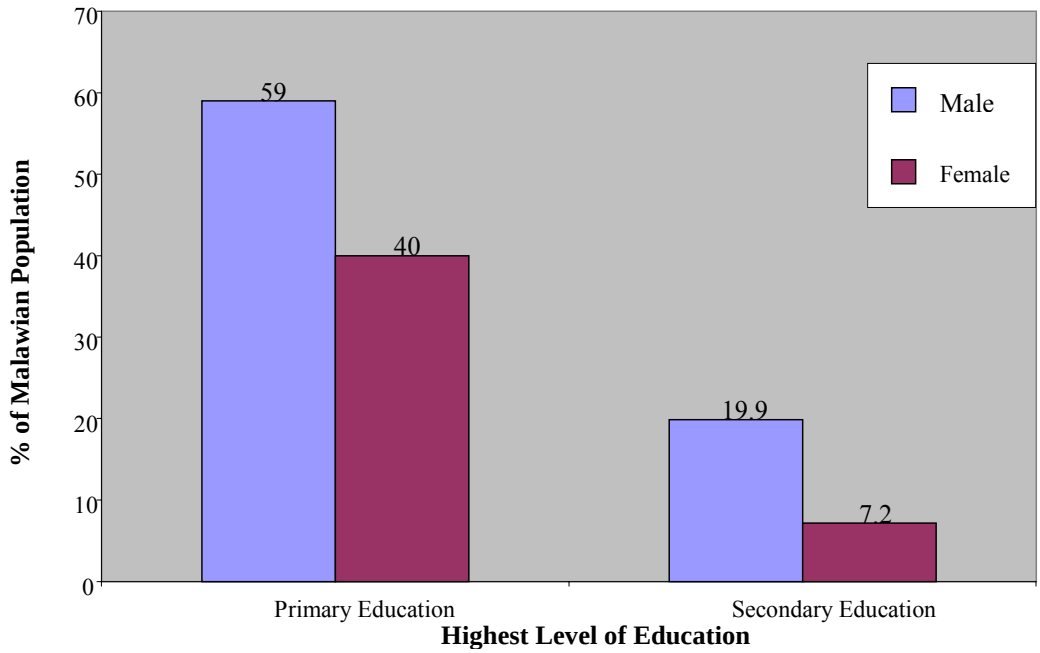
Figure 4.3: *Socioeconomic Status of Malawians by Age*



Source: NSO 2005

With respect to education, Malawi is one of the countries with low literacy rates in the Sub-Sahara Region. The 2004-2005 IHS Report shows that 58% of Malawian adults have completed their primary education while only 17% completed secondary education (NSO 2005). However, the proportion of those who attained the various levels of education varied by sex (ibid.)- See Figure 4.4.

Figure 4.4: *Proportion of Malawian Adult Population and Highest Level of Education Attained*



Source: NSO 2005

The adult literacy rate of population over 15 years old is estimated at 58% while that for females over 15 years old is estimated at 44% (Malawi Poverty Strategy Paper 2002). However, the literacy rate was estimated at 40.8 percent and lower in 1999 and years back respectively before the change of government in 1994 (UNDP 2001). Following 1994, Malawi has achieved a net enrolment rate of 81.5% from an estimated 67% in 1994, attained gender parity in primary education, and a net attendance ratio of 81.5%. Moreover, young people's literacy rate has risen from 63% to 76% (DFID 2007). The rise in literacy rate has been associated with the introduction of free primary education following multiparty government in 1994. Until then, very low rates of schooling and literacy, especially for females and rural dwellers were the norm (Malawi Government 2002). This shows that though boys are given priority in terms of education, if opportunity for education for all is available, girls can also attain education.

Politically, Malawi was under dictatorship rule of Kamuzu Banda since gaining its independence in 1964. During this time till 1994, issues related to SRH particularly HIV/AIDS and premarital sexuality were not discussed openly. However, the emergence of multiparty democracy in 1994 witnessed a political environment that has been promoting SRH including prevention of HIV/AIDS and early pregnancy. To show its commitment, the government adopted the 1994 ICPD Plan of Action in 1994 and expanded its SRH services in 1997 (MoHP 2002; MoHP 1999d). This therefore means young people had access to SRH information and services at the time of the study. However, although adolescents had access to SRH information and services, issues related to sexuality is still not talked about in public and unmarried people are not socially expected to have sex though some traditions encourage premarital sex (CSR 1997; Munthali et al., 2004). Thus, there are ambiguous culture related sexual behaviours for adolescents in the society.

4.4.1.2 Cultural Environment for Adolescent Sexuality and Health

Malawi is a country rich in culture. These cultures shape the people's practices and behaviour (CSR 1997; Lema 1997; Munthali et al., 2004).

Malawi has its own traditional health beliefs and health care practices. Many people in Malawi trust and use traditional medicine. While there have been social change in most

societies following globalisation, there are still ideas on prophylaxis, diagnosis and therapy different from those in western medical paradigm in most societies in Malawi (Phiri 1997; Zachariah et al., 2002). When people are in trouble, they turn to 'doctors' (western or traditions), priests or spiritual healers. Thus, traditional values as well as religious or any other beliefs concerning supernatural powers and forces have not died out with social change. They change and develop new forms and concepts (Castro and Marchand-Lucas 2000; Zachariah et al., 2002; Letamo 2003; Mills et al., 2005). For instance, regardless the level of education attained, most Malawians patronize both the western and indigenous medical system, simultaneously or one after another (Blaxter 1997; Young and Ali 2001; Zachariah et al., 2002; Imogie et al., 2002; Mills 2005) in order to recognize cultural norms and to re-assert their moral worth; and indigenous religious and medical practices and beliefs have been incorporated in many African churches (Phiri 1998).

Traditionally, premarital sex is not acceptable in Malawi probably due to coming of religion in the country. However, young people are taught about sex when they are being initiated from the age of ten years and even below. Due to culture, parents are not usually the sex educators of their children although they are the ones mostly spending time with them. Instead, grandparents and traditional leaders are often given that responsibility (Stewarts et al., 1998). Moreover, traditional counselors locally known as *'Anankungwi',* or *'Ngaliba'*, traditional healers, birth attendants and the religious groups are now giving advice about sex to the youth in most societies (Munthali et al., 2004; CRH 2005).

Although Malawi's culture dictates that young females should abstain from sexual activities until initiated by a traditional advisor following onset of menses, there is increasing evidence that early sexual debut seems to be the pattern among adolescent-girls including among the pre-initiation and premenstrual girls. Many young people engage in sexual activity as early at the age of 10 years or even earlier while the majority report having sexual intercourse by the age 17 years (McAuliffe and Ntata 1994; Bisika and Ntata 1996; CSR 1997; Hickey 1997).

Malawian culture does not condone interactions among boys and girls because of fear of teenage pregnancy, something regarded as a disgrace by both parents and young people (Kanyama 1998 cited in Stewarts et al., 1998). Furthermore, other reports showed that unmarried pregnant adolescents were either being beaten or even disowned by their fathers (ibid.). Until recently, young women who became pregnant jeopardised their chances of getting education as they were expelled from school when their pregnancy was known (Stewarts et al., 1998). Moreover, although people appear to be beginning to be more compassionate towards unmarried girls who become pregnant, the stigma associated with early out-of-wedlock pregnancy is still present in Malawi (ibid.).

Due to fear of out-of-wedlock pregnancies, early marriages are common in most Malawian cultures. Marriage is generally associated with raising females' social status in most societies (CSR 1997). While marriage was only accepted when people were old enough approximately about twenty years, today's youth enter marriage at a very younger age. Other studies conducted recently show that a smaller proportion of young adolescent girls (23%) enter into marriage at the age of 15 while the largest proportion (38.5%) get married by their eighteenth birthday (MoEST 2002). In most districts women marry relatively younger as compared to men (NSO and IFPRI 2002). However, people in urban areas usually marry later as compared to rural areas (ibid.; Government of Malawi 1992; 2000). The early marriages could increase early childbearing which might increase girls' chances of complications related to pregnancies and delivery (UNFPA 2003).

Gender roles also play an important part in moulding and influencing sexual behaviour of young people in Malawi. For instance, young women are traditionally socialised to be subservient to their male partners (USAID 1997; CSR 1997). Moreover, the importance of having children is communicated to women from an early age, and many young women do not see pregnancy and early motherhood as a significant problem (UNESCO 1996; CSR 1997). While parents often disapprove single parenthood, the importance of having children is expressed to girls from a very young age, with subtle and other pressure exerted by family, partners and the community (Stewarts et al., 1998).

Traditionally, Malawian females are taught to be subservient to male partners in sexual and reproductive matters (CSR 1997). Because of this social attitude, females do not have the autonomy to use SRH services without approval of their male partners although most of the contraceptive services except condoms, and vasectomy in Malawi can be used by females. Until recently, the male dominance in SRH was also reflected in some health facility policies that encouraged requirements for consent from male partners in order for females to access some SRH services (JHPIEGO et al., 2001).

Moreover, due to hegemonic attitudes associated with sexuality and reproduction, covert and overt coercion is seen as an intrinsic part of sexual relationships between young people (Stewarts et al., 1998). Their sense of disempowerment, including powerlessness to refuse the sexual advances of their boyfriends or dictate the use of prevention strategies for pregnancy, STIs including HIV/AIDS, is another factor that could risk their sexual and reproductive health (CSR 1997). However, anecdotal reports in Malawi indicate that some educated women to a certain extent have some autonomy to control the decision-making regarding their sexual health (see also Jejeebhoy 1995; Basu 2002).

On the contrary, young men are culturally conditioned that they are controllers of sexual and reproductive affairs in relationships. Men are made to believe that they have to make most decisions on sexuality and reproduction (CSR 1997; Munthali et al., 2004). Furthermore, the prevailing cultures also put pressure on rural teenage boys to engage in sexual intercourse; "*shaking off dust*", to prove their masculinity following initiation especially among Yao tribes (UNESCO 1996). Overall, the cultural traditions in Malawi are ambiguous and can create an environment that can increase adolescents' vulnerability to SRH problems.

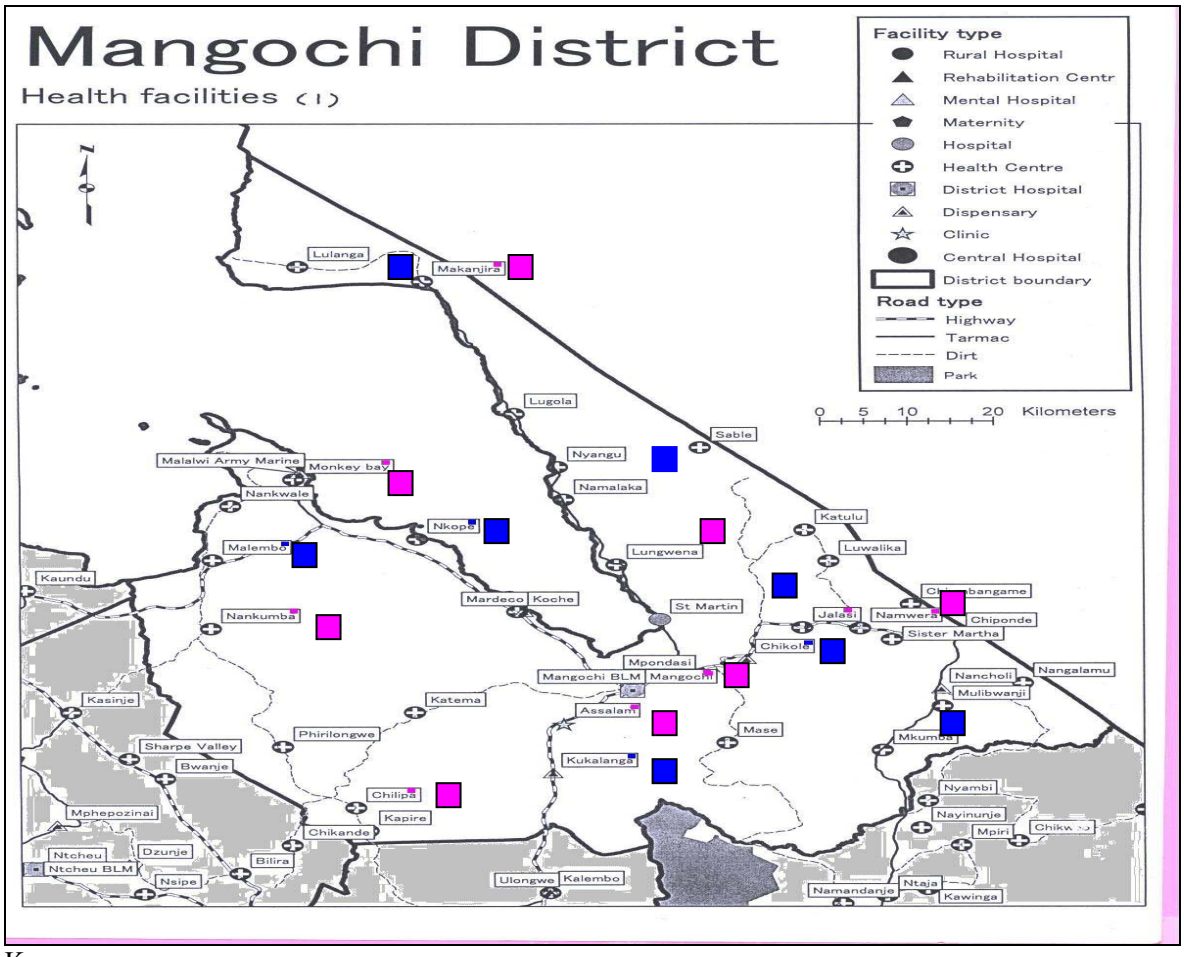
4.4.2 *Research Sites*

Because the study aimed to assess the capacity of facility-based YFRHS, the study was conducted in two different areas: intervention and non-intervention areas (see section 1.9 for definitions). This was done to compare the differences in the level of the adoption of safe sex practices between adolescents who were exposed to YFRHS and those not

exposed to them as well as to compare the determinants of the adolescents' sexual behaviours in the two areas.

The study was conducted in the catchment areas of eight intervention and eight non-intervention facilities. The intervention facilities were Mangochi District Hospital, Chilipa, Monkey-bay, Namwera, Jalasi, St Martin Hospital, Nankumba and Makanjira Health Centres. The non-intervention facilities were Chikole, Nkope, Kukalanga, Malembo, Katema, Lugola, Lulanga and Namalaka (Figure 4.5).

Figure 4.5: *Map of Mangochi District Showing Sampled Health Facilities*



Key

- Intervention Health Facility
- Non Intervention Health Facility
- Outside Mangochi District

4.4.3 *Study Population*

The study population included all unmarried adolescents living in the study areas, unmarried adolescents visiting clinics for SRH services, community elders (initiation counselors, religious leaders, parents/grand-parents) and health service providers.

The inclusion criteria were as follows. Only unmarried adolescents and community members living within eight kilometres radius from the sampled health facilities and had been living in the study areas for at least the past six months were eligible to participate in the study. The catchment area radius of the sampling frame was based on the health facility catchment area map obtained from Mangochi District Health Office.

On the other hand, only health workers who had been working at the facilities for the past 6 months were included. Moreover, while the survey used all unmarried adolescents 10-19 years as the sampling frame; the qualitative phases used only those of thirteen years and above. The age limit was considered based on the pilot study results that showed that those adolescents less than thirteen years were not giving detailed responses during in-depth interviews.

Moreover, only those facilities with trained YFRHS providers working in SRH sections for the past six months and had been implementing YFRHS for over two years were used to ensure that the programme had enough time to work in the catchment areas. In the non-intervention areas, only those non-intervention facilities not sharing other activities with intervention facilities (like youth clubs) and whose catchment areas boundaries were within eight kilometres away from intervention catchment areas boundaries were used. This was done in order to reduce contamination of the non-intervention areas with activities from the intervention areas.

4.4.4. *Sampling Procedures and Sample Size*

Sampling is the process of selecting a portion of the population to represent the entire population in a study (Polite and Hunger 1995). As the study used mixed methods, different sampling procedures were used for various participants.

4.4.4.1 *Participants for In-depth Interviews*

Adolescents, health workers and community elders were used in the in-depth interviews. Purposive sampling was used to select the potential research subjects for the study. This is a procedure of selecting research informants on the basis of their relevance to the research questions, theoretical position and analytical of the study as well as the argument or explanation that the researcher is developing (Mason 2002). The purposive sampling was used as it could offer informants who could provide data that could help in the understanding of the facility's capacity to promote ASRH (ibid.). However, to avoid biases associated with purposive sampling techniques (Mason 2002), simple random sampling was used to select the actual respondents from the potential subjects. In situations where only one potential research participant was available as was the case with the health workers, the available person was used as an informant for the study. In cases where follow-up of some issues arising from the interviews was required, snowballing was used to identify key informants (Robson 2002). The sample sizes for the in-depth interviews were as shown below.

Table 4.1: Sample Sizes: In-depth Interview Participants

Type of Respondents	**No. in Intervention Area**	**No. in Non-Intervention Area**
Unmarried adolescents	5 Males 5 Females	5 Males 5 Females
Health workers	4	4
Community Adults	(***10***) *Community Elders*: 2 males 2 Females *Initiation Counselors*: 2 Males 2 Females *Religious Leaders* : 1 Moslem 1 Christian	(***10***) *Community Elders*: 2 Males 2 Females *Initiation Counselors*: 2 Males 2 Females *Religious Leaders* : 1 Moslem 1 Christian

Additionally, other key informants including court magistrate, two unmarried adolescents who became pregnant whilst at school, two '*chitonombe'* (initiation camp guardians), one YFRH trainer and two primary school AIDS Education teachers were used. The adequacy of the sample size was based on the saturation of the collected data (Bertaux and Bertaux-Wiame 1981; Sandelowski 1995a; Mason 2002).

4.4.4.2 *Health Facility for Participant Observations*

Participant observation was conducted at Mangochi District Hospital (MDH) in the Integrated Maternal and Child Health (MCH) Department. The department provides MCH services, STI services, VCT and YFRH services. Besides MDH, other two intervention (Namwera and Monkey-Bay) and two non-intervention (Nkope and Kukalanga) facilities were periodically visited to assess the patronage of SRH services by adolescents as well as the way health workers handled adolescents clients who came for SRH services. Purposive sampling was used to select the facilities.

4.4.4.3 *Client Exit Interview*

Client exit interviews were conducted at MDH and Kukalanga Health Centre. Systematic random sampling whereby every second adolescent client who visited the MCH clinic for SRH services was interviewed was used (Polit and Hungler 1995). A total of 23 and 12 clients were interviewed at the intervention and non-intervention facilities respectively. The difference in number of clients was due to fewer adolescent clients who visited the selected non-intervention facility (Kukalanga Health Centre) as compared to the intervention facility (MDH) during the study period.

4.4.4.4 *Survey*

Sampling of survey respondents took several steps: household listing, selection of households with eligible participants (unmarried adolescents), sample size determination and selection of respondents.

A. <u>Household Listing</u>

After the study areas were identified and demarcated, household listing was conducted in each study area to list down the number of households in each area. Household listing form was used during the household listing process (Annex 9). During this exercise, the enumerators recorded data of the people in each household. Documented data included number of occupants in each house, names/titles (father, son, etc), sex, ages and marital status. Household listing also identified the location of the eligible participants to establish a sampling frame for the survey and each household with eligible participants was marked

with "X" as an identity for the data enumerators. In total, 1,264 and 1,351 households in were listed in the intervention and non-intervention areas respectively

After the household listing was completed, all the households with eligible participants (marked X) in each study area were listed on a separate paper. The households were then numbered. A total of 1,235 and 1,321 households had eligible participants in the intervention and non-intervention areas respectively.

B. Sample Size Determination

As the study aimed to assess the capacity of facility to promote ASRH, separate samples were drawn from the intervention and non-intervention areas for comparative purposes. The sample size was calculated using the formula below.

$$n = \frac{z^2 \times pq}{d^2}$$

Where n = minimum sample size required in each study setting

z = Standard normal deviation or z-score

p = proportion of sample (males/females) with outcome measure: adolescents using SRH services in intervention areas

q = proportion of sample with outcome measure: using SRH services in non-intervention areas

d = the acceptable error level

The calculation of sample size was based on z-score of 1.96 corresponding to 95% confidence interval and the acceptable error level of 5% (0.05). This was based on recommended standard deviation and error levels in social science research (Bryman and Cramer 1990). The expected proportion of adolescents to be using SRH in the intervention areas was 66% based on Malawi study (Kachingwe et al., 2001); while those using SRH services in the non-intervention areas was estimated at 40% based on Zimbabwe study (Kim et al., 1991). Hence substituting, the sample sizes required in each area was as below:

$$\text{Thus } n = \frac{1.96 \times 1.96 \times 0.66 \times 0.4}{0.05 \times 0.05}$$

$$= \mathbf{405.7}$$

That's, approximately 406 participants were required in each of the areas.

C. Selection of Adolescents

Simple random sampling was used to select adolescents for the study from the list of eligible adolescents. Simple random sampling is a sampling technique whereby each of the units in the sampling frame has the same chance of being selected for the survey (Lemeshow et al., 1990; Polit and Hungler 1995; Polit et al., 2001). This technique was used in order to have a representative sample which could provide the probabilistic foundation of statistical theory (Lemeshow et al., 1990). However, in order to ensure equal representation of males and females, their sampling was done separately. As such, in each area, a total of 203 males and 203 females were required. In order to carry out the procedure, several steps were followed:

1. First, the households with eligible respondents were listed and numbered.

2. List of females was separated from that of males

3. Computer-generated random numbers were prepared. While the actual random numbers was 203 for males and 203 for females in each area, 272 random numbers were generated by the computer for males and 272 for females in each study area. This was done in order to maximize the sample size and thereby improving the validity, reliability and strength of the prediction equation for the results (Stevens 2002). Additionally, extra subjects could be replacements in case some of the adolescents sampled may not be found at their homes during the data collection period or decline to participate in the study.

4. After the numbers were generated, they were then matched with the listed numbers of the households and those households whose numbers matched the generated random numbers were included in the survey sample.

5. In case where more than one eligible participant were found in one household, simple random sampling was also done at household level using computer generated random numbers to select one participant.

6. Where the selected person was unavailable on the interview date, the person below him was interviewed.

D. Description of the Survey Sample

While a sample size of 812 was the minimum required for the survey, 1046 adolescents were sampled representing 523 in each area. While a total of 1,088 participants (544 from intervention and 544 from non-intervention areas) were expected, 1014 were sampled with 523 in the intervention and 491 in the non-intervention areas. The survey used 272 males and 251 female participants drawn from the intervention area; and 272 males and 219 females from non-intervention area. The differences were due to denial of some selected adolescents to participate in the study, some selected adolescents were not at their homes during the interview period; while in some cases some filled questionnaires were not used either because they were not completed or shared same identical numbers and hence could not be traced when call-backs were made. The discrepancy in the number of male and female participants was attributed to the fact that girls entered marriage earlier than boys probably due to culture that allows early or forced marriages among girls (CRH 2004). Other socio-demographic characteristics of the survey participants are as in Table 4.2.

***Table 4.2**: Socio-demographic Characteristics of Survey Rrespondents by Sex and Study Area*

Socio-demographic Variables	***Intervention Area***		***Non-intervention Area***	
	Females %	**Males %**	**Females in %**	**Males %**
Age				*47.8*
10-14	*58.6*	*49.6*	*62.1*	*52.2*
15-19	*41.4*	*50.4*	*37.9*	
Highest Education Level				
None	*5.2*	*2.9*	*5.5*	*0*
Primary	*87.6*	*91.2*	*92.2*	*91.2*
Secondary and above	*7.2*	*5.9*	*2.3*	*5.2*
Currently schooling				
No	*71.8*	*70.6*	*76.3*	*67.6*
Yes	*28.3*	*29.4*	*23.7*	*32.4*

4.4.3.5 *Focus Group Discussions*

Focus groups discussion (FGD) participants were sampled using convenience sampling techniques. Adolescents who were present at youth resource centres on the days the investigator visited the centres were used. Six FGDs were conducted. Two male, two female and one mixed (males and females) FGDs were conducted in the intervention area, and one male and one female FGD in non-intervention area. Each FGD comprised of about 8 to 12 participants. A total of 27 males and 25 females participated in the discussions in the intervention areas while nine females and 10 males participated in the non-intervention areas.

4.5 ***Research Instruments: Design and Measurements***

Data collection tools were developed after a thorough review of literature on social determinants of health behaviour change, adolescent risk-taking models as well as from the researcher's personal experiences.

4.5.1 *Qualitative Research Tools*

Qualitative research tools were adapted from UNDP/UNFPA/WHO/World Bank Special Programme on Research, Development and Research Training in Human Reproduction core data collections instruments (Cleland et al., 1999) and the Focus on Young Adults Data Collection Tools and Instruments (Nelson et al., 2000). These qualitative research

tools were developed to be used in studies that could help understanding factors that could contribute to positive sexual and reproductive health outcomes among young people, especially those that can be influenced by appropriate health-related interventions in developing countries (Cleland et al., 1999; Nelson et al., 2000). The validity of these tools were proved in several countries including in the sub-Saharan Africa (Cleland et al., 1999; Bond 1999).

In addition to the above tools, rigorous piloting of the tools was done in order to ensure consistency of the guides to the cultural context of Malawi. New issues merging from the pilot study results were included in the question guides after discussing the results in a multi-disciplinary team composing social scientists, health workers and community members to ensure that the tools were culturally sensitive and capture socio-cultural issues in the study areas.

The qualitative guides for adolescents, health workers and community members focused on socialisation of young people, the role of social norms in adolescent sexuality and sexual behaviours and the effects of culture on the ASRH promotion (Annexes 10A-12B).

The focus group discussion (FGD) guide focused on the major issues raised in the qualitative and quantitative phase. It focused on socialisation of young people, the role of social norms in adolescent sexuality and sexual behaviours and the effects of culture on the ASRH promotion. Crucially, this guide also focused on the role of gender, stigma and normative culture on adolescent sexual behaviour (Annex 17).

The participant observation checklist focused on staff providers' characteristics and attitudes, implementation of YFRHS guidelines, environment and facility characteristics, health information giving, provider-client interaction, client management and staff competence (Annex 13). On the other hand, the client exit interview tool contained questions that focused on the provider-client interactions during service provision and counseling and information provided among others (Annexe 14).

4.5 *Questionnaire*

The questionnaire was developed based on the preliminary findings from the results from the qualitative phase. Following the initial data collection, the data were analysed and main themes and sub-themes were identified. Discussions on the preliminary findings were made by a multidisciplinary team comprising social scientists, health workers and community members and consensual interpretation made.

Based on the conceptual themes from the qualitative phase, the survey questionnaire focused on knowledge of SRH issues, effects of social norms-related factors such as gender, use of life skills, adolescent sex practices (empowerment), availability of SRH services, provision of SRH services, and quality of services and role of community/parents (Annex 15). These focal point areas were designed to be proxy indicators for health service factors and social/cultural norms-related factors that were used in the logistic regression analysis. The development of the questionnaire involved several steps:

1. Preliminary analysis of qualitative data
2. Identification of key concepts from the data following discussion in a multidisciplinary team
3. Development of questions and responses based on the results
4. Discussion of the questionnaire with other social researchers
5. Pilot testing of the questionnaire
6. Discuss with data collectors the field experiences on the use of the tool
7. Discuss with statistician/ data manager on internal validity of the questionnaire
8. Corrections made based on the above discussions
9. Final Questionnaire developed.

The questionnaire had both open-and close-ended questions. It also contained two types of questions: questions that required self-reporting responses from the respondents and ones where the interviewer had to read out the responses to the respondents (See instructions for interviewers on the survey questionnaire- Annex 15). The self-reported questions were

collecting personalised data regarding the respondent's sexual behaviours. Apart from the questionnaire, review of health service utilisation statistics was done (Annex 15).

4.6 ***Organisation of the Study***

4.6.1 *Field Work Preparation*

The field work preparation started in mid-July 2004 with seeking ethical approval, research assistants' recruitment and training and pilot testing of the research instruments (Annex 1).

4.6.1.1 Ethical Considerations

Before the study commenced, ethical approvals were sought from the College of Medicine Research Committee (COMREC), a sub-committee of the Malawi National Health Sciences Research Committee, and Queen Margaret University. Additionally, consent was sought from Mangochi District Health Office to have access to health workers and documents in the health facilities in the district (Annexe 2).

Moreover, participants were requested to consent their participation in the study in writing or verbally after the data collectors had read out a participant information sheet (Annex 3-4). However, most informants gave a verbal consent. However, where the informant was 13 years or below, a third person over 15 years was also required to consent on behalf of the informant for his/her participation in the study. Furthermore, where fathers who abused their daughters (incest) were interviewed, consent was sought from the traditional leaders before seeking it from the fathers. Besides, the investigator was also accompanied by the traditional leaders' representative when seeking consent from the father abusers for the investigator's security. Information about the interview process, assurance of confidentiality including anonymity was discussed.

Prior to the data collection, the investigator also briefed the Mangochi District Health Management Team and the local leaders from the study areas on the study.

Seeking of ethical approval was not unproblematic in Malawi. While the investigator expected to have difficulties in ethical approval due to the nature of the problem understudy, the process of seeking ethical approval was lengthened due to the ethics

committee's (COMREC) concern over the selection of the investigator's supervisor in the Malawi. As many people considered the research area as being a health issue, many members of the ethics committee felt that the investigator's supervisor was supposed to be a health professional and not a social scientist as was the case. However, after the investigator elaborated that it was QMU's criteria for the choice of the field supervisor, the ethical issues were resolved.

4.6.1.2 Recruitment and Training

The study recruited research assistants (RAs) who helped with data collection and processing. The process of RA recruitment were as follow:

- Advertisement on the recruitment of research assistants was posted in different public places. Qualifications and experiences of the RAs required were outlined on the advert.
- Applications which were received were reviewed and only shortlisted candidates were interviewed.
- Successful candidates were recruited and training was conducted.
- Recruits who had bad performances during the training (practical exercises) were dropped.

The study recruited two qualitative data collectors (one male and one female) with social science background and experience in conducting in-depth interviews. However, as qualitative data collection work progressed, working with indigenous adults proved problematic due to their unwillingness to discuss some sensitive issues like initiation rites with people who had not undergone the rite. This led to the recruitment of four local people (two males and two females) with qualitative research experience that had undergone the local initiation rites to carry out in-depth interviews with local adults.

Apart from the qualitative data collectors, the study also hired RAs for the survey. The recruitment of survey enumerators was done in two phases. Firstly, twenty-five enumerators were recruited to conduct household listing exercise. Youth health volunteers from various villages were used as enumerators.

Secondly, 40 RAs were recruited for questionnaire administration. Thirty-five were used while the other five were on reserve for replacement in case some could not perform to the satisfaction of the investigator. Only youth were recruited in order to create a friendly atmosphere during data collections with adolescents. Additionally, six supervisors with experiences in quantitative research who were accompanying the six groups of the survey enumerators to the field were also recruited. The supervisors' role included on-spot checking for accuracy of the completed questionnaires. They were also responsible for coding the responses before handing them over to the researcher for verification prior to data entry.

The study also recruited two data entry clerks. The recruitment used the SC/US data collectors bank to select six data entry clerks for theoretical and practical interviews (see Annex 23 for research team).

After the recruitment, all RAs were trained. The qualitative data collectors training ran from 27-28th August 2004. The training focused on techniques including use of probes for in-depth data collection and how to build a rapport for effective data collection – see Annex 5 for training programme and topics covered.

The household enumerators underwent a two-day training (August 26-27, 2004)- See Annex 6 for the training programme and topics covered.

The survey enumerators and supervisors training were conducted from 31st August to 2nd September 2004. It was conducted by the investigator, NnN Project Coordinator and the research supervisors. The training focused on the review, piloting, and finalization of the study questionnaire. It also discussed the field protocols, roles and responsibilities of RAs and their supervisors. It also focussed on administration of the questionnaire (how to pose questions, how to check if the responses given match with the questions etc) - see Annex 7 for training programme and topics covered.

The data entry clerks underwent a two-day training (September 8-9, 2004). The training focused on accuracy of data entry- see Annex 8 for training programme and topics covered. The training was done by the investigator and Save the Children data specialist.

4.6.1.3 Pilot Study

The training of the data collectors went alongside the pretesting of the research tools as part of the enumerators' field practice. The questionnaire was piloted in two villages, one in the intervention areas and the other in the non-intervention area which were not used in the actual study. The questionnaires were pre-tested in 2nd September 2004. Each enumerator conducted at least one interview with unmarried adolescent.

Twenty questionnaires were administered in each area and one-to-one face interviews were used. Similarly, the question guides were pre-tested from 30-31 July 2004. Each qualitative data collector conducted two in-depth interviews as part of the field practices. After each interview, each enumerator met the supervisor (survey enumerators) or investigator (in-depth interviewers) to discuss the problems s/he might have encountered in the data collection process.

The results showed that some of the questions were unclear while other questions were duplicated. Other questions like those that focused on the circumcision process were however considered sensitive hence most adolescents were not free to discuss them during the in-depth interviews. These issues were sorted out either by rephrasing and re-wording of the questions in order to ensure consistency and clarity of the items in the questionnaire or deleting the duplicated questions. However, questions that were related to initiation rituals (process of circumcision) were removed from the survey questionnaire.

Moreover, the design of the survey questionnaire needed be redesigned in order to allow running binary logistic regression analysis. These issues were corrected before the actual data collection commenced.

Additionally, discussions were held with a statistician from SC/US to find if the items in the questionnaire could address the research questions. This was done to ensure internal validity of the research tool (Polit and Hungler 1995).

4.6.2 *Data Collection and Data Quality Assurance Mechanisms*

Data collection commenced started on 24th July 2004 and ended on 20th August 2005. It was conducted in three waves following the sequentiality of the research design (Figure 4.1). Wave one was ran from August 2004 to March 2005; wave two from September to October 2004; and wave three was done in April 2005.

4.6.2.1 Data Quality Assurance Mechanisms

Several data quality assurance measures were used to ensure the reliability of the results. For the qualitative data, constructs of credibility, transferability, dependability, confirmability and trustworthiness (Lincoln and Guba 1985; Flick 2003) were enhanced. To ensure credibility, the data analysis team with experience in qualitative research reviewed and coded the data, compared and discussed differences between coding and then clarified the codes. Dependability was ensured by careful transcription and analysis of the data. Additionally, careful description of the decisions during analysis of the data was made. Confirmability was enhanced by the data analysis team's openness to the creation of new themes as these emerged from the data (Flick 2003). Trustworthiness of the data was ensured through early analysis of the initial data to check out for gaps.

Besides, the guides were continuously revised where necessary to cater for gaps before continuing with the data collection. Use of multi-disciplinary team during analysis made the code more reliable. The use of experienced research assistants for data collection was another measure to ensure quality data were collected. Additionally, use of local people to collect sensitive data also ensured the reliability of the data. While this could affect the quality due to some issues that their culture could not want to be known to outsiders, use of detailed question guides helped to reduce that bias. Furthermore, the use of audio-recorders helped the investigator to check the quality of the data collected.

On the other hand, an intensive supervision during data collection facilitated the collection of quality quantitative data. Moreover, the double entry of the survey data and other logistics such as use of data log sheets and questionnaire monitoring sheets (Annexes 20 and 21) when handling the survey data reduced data entry errors and duplication in data entry before data analysis. Training of data collectors also helped to ensure the quality of data.

Lastly, debriefing seminars through FGDs, informal debriefing and member checking of the emerging results with some participants helped to verify understandings some of the issues which were not very clear.

4.6.2.2 Data Collection

A. *Wave I: Qualitative Phase*

Wave one involved data collection using in-depth interviews (unmarried adolescents, health workers and community elders), participant observations and client exit interviews to explore unmarried adolescents, community and health workers views on social determinants of ASRH practices and the effects of social values on health facility's role to promote ASRH (see Annex 1 for time schedule).

Participant observations were conducted by the investigator to assess how social norms affected the quality of service delivery to young people. Observations took place in both formal and informal situations. This helped to uncover the 'behind the scenes' data that proved to be more significant to the study. The investigator used a standardised checklist to record the activities, interactions and other observations occurring at the facility. The data collected included reception of clients, provider-client interactions, counseling, consultation time, confidentiality and privacy, and services unmarried adolescents had access to.

While there was initially change of practice among health workers due to the presence of the investigator at the commencement of the observation exercise, the situation changed

eventually as the investigator became more and more part of health providers' team (Misra et al., 1982; Rogow 1991).

Client exit interviews were conducted to assess social values affecting provision of care to adolescents. The data collected included client perceptions about reception, how providers were reacting to clients' complaints, how clients were handled in the process of care giving, follow-up arrangements, information giving, the assessments of clients, access to services, consultation time, confidentiality and privacy, and impact of their experiences of the visits on their future SRH practices.

Semi-structured interviews were conducted by the investigator and the research assistants to explore unmarried adolescents, community elders and health workers' views on social determinants of SRH practices among unmarried adolescents. The interviews also helped to uncover the role social norms played in influencing how health workers, communities and unmarried adolescents in their participation of ARH promotion activities. Interview guides were used as a checklist to ensure that same questions were posed to all respondents to ensure consistency of the data. However, other probes were used to collect rich data. One-to-one interviews were used and the conversations were audio-recorded (Figure 4.6).

Figure 4.6: *An Interviewer during Data Collection Process*

Each interviewer conducted two interviews per day and each interview took about 45minutes to one hour.

Where an emerging issue was unclear during the interview, it was noted and theoretical sampling was done to clarify the issue (see Annex 18 for theoretical sampling questions). Similarly, where an interesting theme had arisen, follow-up of such issue was done. For instance, the investigator had in-depth interviews with some informants when he learnt about girl-child defilement practices in the community. This was done in order to have an in-depth understanding of the issue. However, where respondents were giving similar information (data saturation), the investigator stopped collecting data on such themes and concentrated on themes that were not clear or partially responded to in the previous interviews (Finlay 2003).

The preliminary results from this phase were used to develop the survey questionnaire that was administered to unmarried adolescents in the second wave.

B. *Wave II: Quantitative Phase*

After training, the quantitative data collectors were grouped into six teams and deployed to six enumeration areas (EAs) devised during the study. An EA was an area classified according to the type of facility serving the area and had clearly demarcated boundaries which were obtained from the MDH Office. Each team had a designated team leader and was assigned to one EA. The supervisors coordinated the data collection in the EAs.

The survey collected quantitative data on demographics, SRH knowledge, and impact of community involvement, access to facility health services, community health services, sexual relationship norms, gender roles and life skills on the adoption of safe sex practices.

During the exercise, all households with eligible adolescents were visited and one-to-one interview was held with the selected adolescent. The questionnaire had two types of questions. One type involved those where the interviewers just posed the questions to the respondents without giving them options of responses. Then, the interviewers recorded

self-reporting responses. The other set of questions required the interviewers to read out the questions and the options of the responses. The interviewers recorded responses the respondents chose from the given options (see instructions on the questionnaire – Annex 15). Each enumerator was conducting five interviews per day.

After the data collectors had completed an interview with an adolescent, they submitted the filled questionnaires to the supervisors who were conducting on-spot check for accuracy on the completion of the questionnaires. Where mistakes in filling or queries related to the information were identified, it was given back to the enumerators for verification with the informant.

C. *Wave III: Qualitative Phase*

This wave used FGDs that discussed the main themes that emerged from the previous phases in order to have consensus on the themes. The FGDs focused on stigma, cultural norms, gender roles and tensions between cultural and western models of ASRH promotion. Two homogenous groups of male and female adolescents were used in each study area. Additionally, one heterogenous group was used in the intervention areas. This heterogeneous group helped to understand some gendered issues emerged in the other groups and the conflicts such gendered issues could have on SRH agency.

FGDs were conducted by the investigator and a research assistant. The investigator was the moderator while the research assistant was the observer. The research assistant was also taking the main issues that needed to be discussed further. FGD question guides were used and the discussions were audio-recorded. Equal participation in the groups was encouraged by moving in circular manner to avoid domination of some participants.

Throughout the data collection exercise, Chichewa language was used except during the initiation counselor interviews where Yao language was used (see the research instruments in the Annex).

4.7 ***Data Management and Analysis***

4.7.1 *Data Management*

All qualitative data were transcribed. Two persons were used to transcribe it in order to compare the accuracy of the data. Each transcript was then audited by the investigator against the original audio-tape. Apart from ensuring that transcripts represented what was in the tapes, the auditing helped the researcher to gain a '*close contact and familiarity ...' with the data*' (Boyatzis 1998:45). In the process of auditing, transcripts were also edited after the investigator discussed with the transcribers to ensure consistency of meaning. Transcribing and auditing of each audio-tape took about 45-minute to three hours.

After each transcript was transcribed and audited, it was given an identity marker representing study area where data was collected (*e.g. Intervention Area 1 or Non-intervention Area 1 or Intervention facility 1 or Non-intervention Facility 1*), participant identity (e.g. *Male/Female Adolescent 1, X years, health worker 1 and Male/Female community elder 1*) age and sex except for health worker where sex was almost universal as most of the providers were females. Five copies of each transcript were made in preparation for data analysis.

As stated earlier, when the quantitative data were collected, the supervisors also did on-spot-check of the questionnaires in the field for accuracy in the completion and coded the responses in preparation for the data entry. Whenever there was a problem in the completion of the questionnaires, they were asking the enumerators to verify or complete the questionnaire with the informant.

After returning from the field, the supervisors were filling the questionnaire monitoring sheet (Annex 20) and the questionnaires were given to the investigator. The investigator also checked accuracy of the completed questionnaires and the coding. After verification, the completed questionnaires were handed over for the data entry. However, if there were any errors in the questionnaires, they were returned to the supervisors for call-backs to verify the data provided.

Data were entered using *Epi-Info for Windows* (version 6.04). Each questionnaire was entered twice by two different data entry clerks to ensure accuracy. After entering each questionnaire, the data entry clerks recorded it in the questionnaire data entry log sheet (Annex 21) and then archived it. In addition, after the questionnaire was entered, the data entry clerk recorded it in the data entry log sheet (Annex 21).

Following data entry, comparison of the two data sets was done using *Epi-Info* software to verify if there were any errors in the data entry process. When an error was identified, the archived questionnaires were retrieved for a physical check to identify and correct the error. However, if the errors were grave, the questionnaire was re-entered. Finally, the data were exported to *SPSS for Windows* (version 13.0) for analysis.

4.7.2 *Data Analysis and Interpretations*

4.7.2.1 Qualitative Data Analysis

Qualitative data analysis was undertaken using a three-stage thematic analysis that adopted grounded theory approach (Annex 22). Thematic analysis is an approach to dealing with data that involves the creation and application of codes to data (Morse 1991b; Sandeolwski 1995b; Gibson 2006). The data were analysed manually in which transcripts were read and reread numerous times by qualitative data analysis team that comprised the researcher and four research assistants with different professional backgrounds- social scientist, health professional, adolescent health specialist and a community representative (Figure 4.7).

***Figure 4.7**: Qualitative Data Analysis Team at Work*

The team members coded the data. The use of multi-disciplinary team members improved the reliability of the codes as they were discussed prior to being used (Mile and Huberman 1994). Thus, because the coding of the entire transcripts was done by various coders with different backgrounds, this helped to compare the meanings and interpretations of the data and eventually improved the reliability of the results as the codes and their descriptions were discussed and conclusions were reached before endorsing them (Aronson 1994).

Data analysis was done through the process of coding. Strauss and Corbin (1990) define coding is the process which "*... represents the operations by which data are broken down, conceptualised, and put back together in new ways*" (p:57). Coding was based on deductive and inductive processes (ibid.). While the inductive coding was based on the meanings or constructs grounded in the data, deductive coding was based on the priori constructs from social identity theory (Tajfel 1986) on adolescent sexual behaviours and the capacity of health facilities to promote adolescent sexual practices. Social identity theory highlights the need for social scientists to study adolescents' behaviours as a process of social identity development rather than in isolation from their social context. Thus, individual behavioural choices were considered as the products of social influences rather than individual choices alone.

The thematic analysis in this study followed a three-phased coding of grounded theory: open, axial and selective (Corbin and Strauss (1990).

The open coding involved identifying, naming, conceptually categorizing, labelling and describing phenomena found in the text through the process of construct comparative method (Miles and Huberman 1994). Comparative method involved the asking of questions and the making of comparisons between transcripts. Data were initially broken down by asking simple questions such as *what* do the data say, *where* was that said, *how* was that said, *when* was it said and *how much* emphasis was put on the said point.

During open coding process, each of the members was reading a transcript of one respondent. As they read through the transcript, each identified common themes as well as other atypical observations (Miles and Huberman 1994). Coding was based on the repetition of key word, phrase or statements in the transcripts (D'Andrade 1995; Ryan and Bernard undated). The identified themes were highlighted using different colours to colour-code them so that they can be retrieved at a later stage for further comparison and analysis (ibid.). Moreover, each time a theme was identified; remarks or identification tag was written in the margin of the transcript.

However, to ensure that there was no bias in the analysis of the data, some non-repetitive words, phrases or statements that appeared to bring in new dimensions to the understanding of adolescent sex practices were also critically analysed for theme identification (Ryan 1999). Thematic data analysis followed an iterative process in theme generation and coding was done both formally and informally. Each identified theme was written on a *Post-it* pad and then posted on flip chart stuck on the wall.

After reading and rereading of the transcripts, the analysis team members compared their understandings of contents in terms of major themes, point of agreement, and areas where there was dissention and disagreement. Numerous discussions among members refined these first impressions of the data into agreed themes, around which further thinking and writing were structured. In the initial analysis, the focus of the questions on the research tools suggested the codes such as common ASRH problems, sources of SRH information, sources of health care, role of health facility in ASRH promotion, adolescent and community participation in ASRH issues, barriers to SRH use among unmarried adolescents. Subsequently, the themes/data were compared and similar incidents were

grouped together and given the same more abstract conceptual label in the process called categorising (Miles and Huberman 1994).

Unlike open coding which broke the data into concepts and categories, axial coding involved putting those concepts back together in new ways by making connections between them as categories and sub-categories. Thus, axial coding involved making relationships between the codes and developing the main categories and their sub-categories (Miles and Huberman 1994). The codes were related to each other via a combination of deductive and inductive thinking (Strauss and Corbin 1990). During the axial coding, the group reorganised the concepts identified in the open coding to make conceptual flow diagram and to finalise the definitions of the themes (see Annex 19). Thus, the revised clusters were synthesized (Strauss and Corbin 1990).

Axial coding was based on causal relationships between the concepts; and aimed to fit the data on social identities, ASRH behaviours and health promotion into a basic frame of generic relationships (Scott and Howell 2008). The causal relationship matrix/guide identifies the relationships and interactions of the categories one with the others. It also described how the consequences of each category (in this case social identity issues) were understood (ibid.). Thus, axial coding linked and organised categories by relationships (Glaser and Strauss 1967; Strauss and Corbin 1990). T

The causal relationship matrix consisted of the following elements: phenomenon, causal condition, context, intervening condition and consequences. *Phenomenon* identified the central theme (adolescent sexual behaviour); the *causal condition* identified events that led to the occurrence or development of adolescent's sexual practices as well as set of causes and their properties; *context* defined the particular set of conditions that influenced adolescent sexual behaviours or their response to the sexual practice in the society. The *intervening condition* or *strategy* or *action* identified a goal oriented actions or response that occurred as a result of the adolescent sexual behaviour; while *consequences* identified intended and unintended outcomes of the actions or responses (Scott and Howell 2008). The causal relationship facilitated the comparative and investigative questioning about adolescent SRH behaviours and the factors that led influenced or hindered their SRH

promotion efforts. The emergence of key properties, dimensions and modes of understanding the consequences of social identity issues on adolescent SRH promotion behaviours or efforts was the indicator that the analysis reached theoretical saturation (Glaser 1978).

Lastly, selective coding involved group reflection and interpretation to uncover the meanings implied in each identified statement/theme and to determine the central themes in the data (Wolcott 1990). In other words, selective coding was an interpretive process whereby the concepts were translated into the more theoretical concepts (Strauss and Corbin 1990).

Selective coding was done using reflective coding. Reflective coding was designed to paint a picture of the central social identity issues, adolescent sexual practices and health promotion practices, defining and describing them in a manner sufficient to account for the collected data holistically as a narrative or a story explaining the substantive theory of the above central themes (Scott and Howell 2008). During this phase the analysts took a more holistic constructive perspective of the data to identify the essential processes, sub-categories related to the descriptors of the central themes in order to come up with a more abstract core category. This process was rather like putting a jigsaw puzzle together trying a piece at a time through multiple interactions until all the pieces formed a narrative picture that fits the data (ibid.) in order to generate a story or story-line. A story can be described as a narrative about a central theme of the study while a story-line is the conceptualisation of the story in abstract way (Scott and Howell 2008). Story-line led to the core category (central category). Thus, selective coding involved integration of the categories that were developed to form the initial theoretical framework.

The core categories generated from the data were role of cultural and social norms in adolescent sex practices, role of stigma and gender in ASRH, cultural and modern approaches to ASRH promotion, fishing industry and social identity, SRH use/sexual behaviour and social identity and health facility and conscientisation. In the final phase of data analysis, the influences of social and cultural identities emerged as the main themes and were categorised into six main themes: ambiguous normative culture, structural

gender asymmetry, stigma and discrediting social identities and behaviours, cultural and modern health care tensions, challenges of YFRHS to transform social identities and facilitation of social change process (Annex 22 for detailed thematic analysis output). Thus, while the initial research questions had focused on exploring the determinants of ASRH, the continuing data analysis pointed towards a re-focus on social and cultural values and how they impact on ASRH in culturally-conservative contexts.

Analytic memos were documented throughout the analysis on multiple codes and overlapping concerns, such as norms and gender, norms and stigma and roles of social identities in sex practices, change process for individual and community and YFRHS and role of social consciousness. Memos were short documents that the researcher wrote to himself as he proceeded through the analysis of the transcripts (Strauss and Corbin 1990). Memo writing was an integral part of the study in order to keep track of all the categories, research questions and generative questions that evolve from the analytical process (ibid.). It also helped in developing questions used to clarify other emerging issues (Annex 18).

Moreover, during all the phases of coding, comparison of texts from one transcript to another was done in order to develop conceptualisations of possible relations between various pieces of data (Glaser and Strauss 1967a; 1967b; Thorne 2000). This comparative analysis processes helped to develop ways of understanding adolescent sexual behaviours within the context in which they were experienced. To foster the creation of a conceptual understanding of ASRH issues, the codes were logically organised through a group process of examining the codes and linkages among the codes from the transcripts.

However, the qualitative data analysis was not unproblematic. Some themes and sub-themes were related to more than one core category and that made it difficult to assign them to one category. However, the themes were assigned after the analysis team had discussed and agreed on the category each theme was to be attached to. In some cases, one sub-theme could also belong to several categories.

4.7.2.2 Quantitative Data Analysis

Quantitative data were analysed using *SPSS for Windows* version 13.0. Both descriptive and inferential statistics were used. Descriptive statistics focused on the background of the

respondents. Inferential analyses focused on comparison of factors that influenced behavioural change among adolescents in the intervention and non-intervention areas. Chi-square test was used to compare impact of facility-based YFRHS on behaviour adoption between unmarried adolescents in the intervention and non-intervention areas. Besides, impact of community-based ASRH services was analysed. Within and between study areas chi-square tests were applied to examine the effect of various factors on SRH behaviours within and between the study areas. Between-chi square tests compared the proportions of adolescents adopting SRH behaviours in the intervention and non-intervention areas. Within-chi-square tests compared the proportions adopting specific behaviour in a particular study area after introducing a particular independent variable. This analysis approach facilitated understanding of the effects of availability of YFRHS on adolescent SRH practices

> By separating out the between-area and within-area contribution of area effect, it is possible to see the extent to which they actually explain any differences between area, once the characteristics of the individuals who reside there have been taken into account (Joshi in Graham 2004: 144).

Additionally, binary logistic regression analysis was used to assess the associations between various variables with the adoption of safe sex practices. The analysis only used the independent variables that showed significant association when used to run the Enter Method with the dependent variables. The Enter Method is a procedure that enters all the variables and predicts the contribution of each towards the achievement of the dependent variable (Norusis 1988). The data analysis in the two samples (intervention and non-intervention areas) was done separately in order to assess the variation in the impact of the various determinants in the two areas.

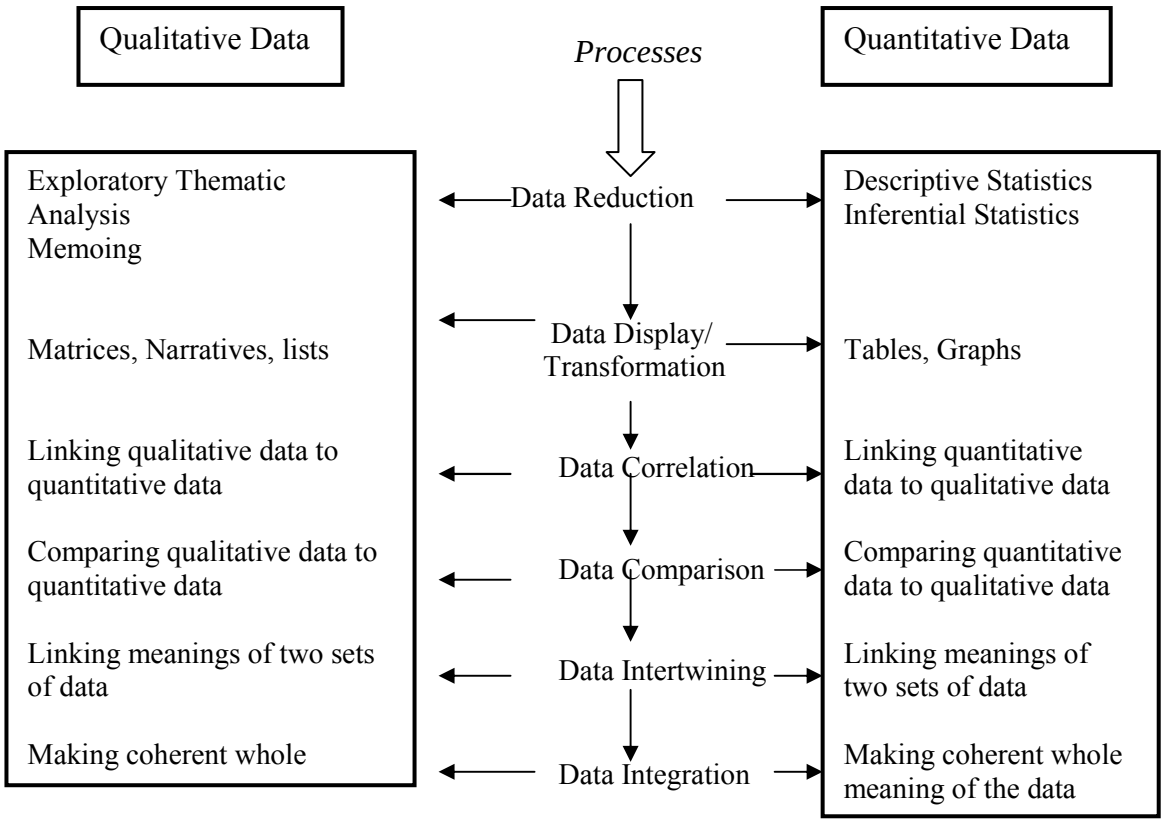
To evaluate the multivariate associations of the various independent variables with each behaviour, backward stepwise logistic regression model that included all independent variables that were significant at the p=0.05 bivariately was computed. The backward stepwise logistic regression is an exploratory analysis where the analysis begins with a full or saturated model, and variables are eliminated from the model in an iterative process and the fit of the model is tested after the elimination of each variable to ensure that the model adequately fits the data (Tabachnick and Fidell 1996). This analysis assessed the cumulative effect of the independent variables on behavioural outcomes (adoption of safe

sex practices). Factors such educational status, sexual relationships, gender, assertiveness, parental involvement in SRH education were used as proxy indicators for effects of social identity factors while access to SRH services and residing in the intervention areas were used as proxy indicators for effects of YFRHS. However, the analysis only allowed establishing associations, but not causal relationships (Erulkar et al., 2004). Hosmer and Lemeshow test which assesses how well data fit into a model was used as goodness of fit test (Hosmer and Lemeshow 2000; Pallant 2005; 2007; George and Mallery 2007).

4.7.2.3 Data Interpretation

The study adapted Onwuegbuzie and Teddlie's (2003) approach to interpreting mixed methods data. The approach included data reduction, data display and transformation, data correlation, data comparison, data intertwining, and data integration of the quantitative and qualitative findings (Figure 4.8).

Figure 4.8: *Data Interpretation Process*



Key to the interpretation was the link between the qualitative and quantitative results (McMillan 1996; Onwuegbuzie 2003). This approach strengthened the validity of the results and conclusions as neglecting the interactions when testing hypothesis in sequential mixed analysis could result in wrong conclusions

> By not formally testing the interactions, researchers may end up selecting a model that does not honour optimally the nature of reality that they want to study, thereby threatening the internal validity of the findings (Onwuegbuzie and Leech 2004:781).

After the data were analysed, the results were disseminated to the various stakeholders including the health professionals, community members, NnN staff and the adolescents in order allow them to reflect on the current YFRHS programme and to draw a way forward for the implementation of YFRHS activities in the district (Figure 4.9).

Figure 4.9: *Preliminary Results Dissemination Meeting*

This forum also allowed the participants to discuss the results which enriched the collected data.

4.8 ***Role of the Researcher***

As the study is founded on interpretive paradigm, the investigator was involved in an intensive and sustained contact with the participants. This introduced a range of strategic, ethical and personal issues into the research process.

4.8.1 *Positionality*

Several studies have called on social researchers to recognise their own positionality in research in order to explore the phenomenon understudy with no or little researchers' interruptions (Jackson 1993; Smith 1993; Rose 1997). Positionality is a term used to describe how people are defined, that is "*not in terms of fixed identities, but by their location within existing networks of relationships which can be analyzed and changed"* during research process (Maher and Tetreault 1994:164). Positionality is thus the 'lens' through which to view the interactions between researchers and the researched (Calabrese Barton 1998). Positionality may include aspects of identity (like gender, class, sexuality and others) as well as personal experience of research (such as research training , previous projects worked on) that may influence the interactions between the researcher and the researched (Hopkins 2007). Understanding and mobilising positionality is crucial to effective data collection and analysis because various identities of the researchers may influence and shape encounters, processes and outcomes of the studies (Valentine 2002; Vanderbeck 2005).

As the researcher previously also worked as a CHAPs Programme coordinator and thereby interacted with the MoH staff and the community in the study setting, the researcher had multiple identities (as health worker, manager, researcher, a Christian, head of a family) in the study setting that could influence the research process. While the methodological approach to the study required the researcher to be an 'outsider', his familiarity with the communities in the study setting made him an 'insider'. Thus, in some situations people in the community considered the researcher as an insider because of the researcher and community's commonalities like nationality, colour, familiarity with the study setting[6] and ability to engage in regular conversation in the local dialect (language) (see also Sultana 2007).

On the other hand, others considered the researcher as an outsider because of the researcher's education, his research role and lack of shared views between the researcher and the community on traditional rites such as 'traditional initiation'. Additionally, the

[6] As the researcher's work involved working in partnerships with MoH and other NGO staff as well as the community including adolescents on issues related to sexual and reproductive health, the work facilitated the community's familiarity and closeness to the researcher.

researcher's Christian religious values and beliefs were different from those of the majority of the society who were Muslims. Also, the researcher's tribal affiliation (Nyanja) was different from the local society (study setting) where the majority are Yao (see Government of Malawi 1999). These differences also mean that the cultures informing sexuality of unmarried adolescents were different between the researcher and the researched. While the researcher's culture on adolescent sexuality was mostly informed by the Christian religion values, the study population's adolescent sexual culture was influenced by the society's social traditions (see section 2.1.3; Kaler 2004).

This blended insider-outsider position had benefits, challenges and implications for the research process. In terms of benefits, the investigator's familiarity with the community facilitated instant access to and rapport with research participants (see also Harvey 1996; De Andrade 2000; DeLyser 2001; Sheriff 2001Merriam et al., 2001; Chavez 2008). Also, because the investigator had worked in the study area before as a social/health development practitioner, there was cooperation from the potential research subjects to participate in the study. The institutions with which the researcher interacted before (e.g. community members and groups, MoH facilities, adolescent groups and other NGOs) also showed eagerness to cooperate with the researcher in the research process. They were eager to learn about the research findings to inform the further development of their programme.

Furthermore, the researcher's insiderness facilitated access to more 'in-group' activities such as attending some traditional rites which could not be accessed by an outsider (see also Kondo 1986; Sheriff 2001). Moreover, because of the community's familiarity with the researcher, the position of the researcher as perceived by residents in the research setting was not anything new. In some instances, it was noted that the traditional leaders seemed to be aware of whatever the researcher would be doing as they gave responses like, *'Go ahead, different groups of people visit our villages to discuss with the youth and the community about the youth's sexual health and people in this community already know about your work'* when the researcher asked for permission to have interviews or discussions with the adolescents and community members in their communities.

Besides, the researcher's insiderness provided an insight of understanding the linguistic, cognitive, emotional and psychological precepts of the research participants as well as the historical and practical day to day events in the study area (see also Chavez 2008).
Lastly, familiarity and closeness to the people in the community also helped the researcher to collect data using some informal interactions such as occurred in daily conversation. In this regard, the researcher was at times, a participant observer (compare Fontana and Frey 2005). Participant observation was particularly useful when the standard use of recording equipment was problematic like when observing behaviours such as traditional initiation rites where it was unacceptable to record the actions or conversations (see also Scheiberg 1990; Miller 1997). These participant observer approaches therefore allowed acquisition of inside and in-depth knowledge that enriched the data. In this way, the researcher's familiarity and closeness to the community contributed to a nuanced and unique insight into issues related to sexual behaviours among unmarried adolescents in the community (see also Banks 1998; Chavez 2008). On the other hand, the researcher's outsider positionality helped him to be a 'learner' of the social issues rather than a 'knower/informant' during the research process.

However, 'insider' positionality also posed challenges to the research process. The insider positionality could negatively affect the data collection process. Researchers in this position could have biases in interviewing (Zavella 1996) or may not seek in-depth understanding of the issues as they consider themselves as 'knowers' of the issues being investigated (see also limitations of the study, section 4.9). In this way, awareness of insiderness challenges the investigator to be fully and continually cognisant of his researcher role (see Zavella 1996; Brayboy and Deyhle 2000; Kusow 2003). Additionally, the researcher's social values like religious beliefs might constrain the questions he asks and how he asks them for fear that people might consider the researcher as a 'socially immoral' person (see Chavez 2008). Being influenced by internally held moral or social positions thereby has the potential to compromise the data collection process and thereby constrain the researcher's performance of the research role and objectives (Parameswaran 2001). On the other hand, if respondents are familiar with the researcher's values, they might respond in a way that they know will not offend the researcher's known or perceived identity (Book-Betts 1994; Merriam et al., 2001).

Also, due to fear that the researcher's reputation may be lowered particularly if he is seen to promote norms that are contrary to the societies', there could be a bias in selecting research participants so as to avoid people who might critique the tone and direction of the research questions. In this case the researcher might select respondents who share the same internal values as himself and as a result will not be able to gather data from people who are unsympathetic to the researcher's personal position on, in this case, promotion of sexual health among unmarried adolescents. This can comprise the depth of the collected data. However, while purposive sampling[7] was used to draw the list of the eligible research subjects for the in-depth interviews and FGDs, the use of simple random sampling to select the actual respondents/participants for the interviews/FGDs reduced the biases associated with purposive sampling techniques (Mason 2002) (see section 4.4.4.1).

The insider positionality could also lead to selective reporting or failure/difficulty to recognise patterns in the data during analysis due to familiarity with the community (Chavez 2008). The failure to be aware of and analyse the 'taken for granted' might mean that the researcher overlooks some of the themes which might otherwise emerge from the data as important influences on sexuality among unmarried adolescents.

Importantly, the researcher's skills acquired during his research training at QMU especially on '*positionality and reflexivity*' in social research helped him to counteract such influences of social values and norms especially if conducting a study in one's home environment. This training prepared the investigator to move reflexively and appropriately from insider to outsider positions and vice versa during the data collection. This was facilitated by using a detailed interview guide and memoing[8] during data collection process in order not to forget probing on some important issues.

In the writing-up phase of the research, the researcher's positionality was exercised as he wrote a piece about his own experience of sexuality to inform a discussion with his supervisors. This enabled the researcher to achieve increased objectivity as he moved in

[7] Purposive sampling is a procedure of selecting research informants based on their relevance to the research questions, theoretical position and analytical of the study as well as the argument or explanation that the researcher is developing (Mason 2002).
[8] Memoing refers to the documentation of key themes that emerged during data collection in order to further investigate on them.

and out of the data, analysing it in increasing depth towards the end of the research process.

The use of data and methodological triangulations in the research design and process also assisted to strengthen the objective/outsider positionality of the researcher during the data collection and analysis because the existence of mismatching data from different data collection methods encouraged the researcher to carry out further investigation in order to understand the mismatching data (Creswell 2003).

Also, due to the investigator's familiarity with the communities, some participants were concerned that the researcher was asking them to explain obvious things. For example, asking the adolescents why some adolescents do not visit health facilities, some of the responses started with phrases like: *As you already know……, As you are familiar with our hospitals.....*were common. This limited their contributions to the issues being discussed. However, the investigator used different techniques to encourage respondents to open up. For instance, questions like *could you remind me what was being discussed in the meetings about … or what actually you are talking about…* were used. In some instances, the researcher used to begin the interviews with a disclaimer like – *I know you'll feel like I know some of the things I will be asking you. But let discuss it as if you are telling somebody who doesn't know anything about the issues as it happens in this area.* This disclaimer encouraged the participants to give in-depth information about the issues being discussed (see Miller 1997; DeLyser 2001).

Moreover, despite being a Malawian and a health professional who had previously worked in the study setting, attributes that could make the researcher an insider, he was largely considered as an outsider due to the tribal and cultural differences (see above). Because of this, the researcher had limited access to certain data like that for traditional initiation rituals. In this case, the researcher used well trained local interviewers who shared same culture with the initiation/traditional leaders to collect data from them. However, to avoid compromising the data, audio recorders were used so that the researcher could check the depth of the data.

Furthermore, the community's familiarity with the investigator as the former health project coordinator raised high expectations of the benefits the study would bring to the society. For instance, one adolescent expressed; '*May be this will help to make the nurses not to shout at us again when we visit the clinic'* (Female Adolescent, 17 years, Intervention Area 2). However, the researcher kept on informing and reminding respondents on the primary use of the data collected and not to expect immediate changes.

Overall, the insider-outsider status posed methodological benefits and challenges particularly on issues around positionality in research process, researcher's sense of self and the situated knowledge the researcher possesses as a result of his location in the social order (Chavez 2008). In this study, the researcher properly negotiated his positionality, drawing on his own diverse social identities (Labaree, 2002) during interactions with participants in order to avoid biases in the research results and conduct reliable and ethical research (Hopkins 2007).

4.8.2 *Reflexivity*

As the researcher's values, beliefs, culture and interests could influence research, reflexivity was an important part of the research process. Danielewicz (2001) describes '*reflexivity as an act of self-conscious consideration that can lead to a deepened understanding of themselves and others, not in abstract, but in relation to specific social environments …[and] foster a more profound awareness … and how social contexts influence who people are and how they behave* … (p.1555). Nightingale and Cromby (1999:228) add

> Reflexivity requires an awareness of the researcher's contribution to the construction of meanings throughout the research process, and an acknowledgment of the impossibility of remaining 'outside of' one's subject matter while conducting research.

As the researcher has almost a similar cultural background with the society in the study area, this could have affected his critical reflection of the actions and behaviours of the people that might be oppressive to unmarried adolescents' sexual rights in the study area. However, due to his knowledge of effects of such practice, the researcher was cautious to avoid his influence in the research process. Moreover, as the investigator had an assignment to write a reflective practice paper of his life particularly his beliefs about

adolescent sexuality in Malawi, this also helped him to become conscious and aware of the potential bias of his constructions of the meanings of the collected data/observations. Because of this, the researcher was conscious of his role and the role of the respondents in the study.

Furthermore, the use of detailed interview guides helped to ensure that in-depth data were collected during the data collection and this reduced researcher's involvement in the construction of meanings in the study. Similarly, the use of checklist during the participant observations at the health facility ensured that all important areas were questioned and observed. In addition, the outsider position taken by the researcher (non-knower, novice) encouraged him to be critical of the policies and theories informing the health service provision (Jackson 1993; Smith 1993).

As the researcher's interests could also influence his data collection and analysis process, use of theories informing data collection and analysis reduced the researcher's bias.

Moreover, the epistemological reflexivity helped the investigator to examine how the study could be improved. The reflection on research design showed that the design provided a flexible approach to understanding adolescent sexuality. It provided the opportunity for the researcher to investigate on issues that were not initially on the guides but had come out during the interactions with society. As such, the design helped the investigator to have an in-depth inquiry of the social determinants of adolescent sex practices and the capacity of health facilities to address them.

Overall, researcher's awareness of the his values, interests, experiences and others that might impact on the research helped him to be cautious of the research process in order to reduce biases in data collection, analysis and interpretation. Besides, epistemological reflexivity helped the researcher to identify the limitations of the study design in understanding adolescent sexual behaviours and the capacity of health facilities in ASRH promotion in culturally-sensitive societies.

4.9 *Limitations of the Study*

The study was subject to several limitations. The investigator's identity as a professional who previously worked in the health sector in the study area might affect the quality and

type of responses given by the informants. For instance, some informants could not provide detailed information during discussions especially when they felt that the investigator knew better and consider him as an expert (Beynon 1983; Golde 1986). However, the use of detailed research tools helped to solve the problem.

Moreover, as the study was perceived to be associated with biomedical institution (hospital) due to the association of the investigator with MoH and NnN staff during fieldwork, this might influence informants to give answers that were seen by the respondents as appropriate to the biomedical institutions [Hawthorne effect] (Polit and Hungler 1995). However, the use well-trained research assistants might have helped to reduce that bias.

Furthermore, as the behavioural outcomes were based on self-reported information, this could be subject to reporting errors and biases (Turner et al., 1998; Magnani et al., 2002b). However, the methodological triangulation used could minimise such errors (Creswell 2003).

Also, because adolescents and community informants were not controlled in their movements between the intervention or non-intervention areas, these informants might have access to SRH information or services or programme activities aimed at creating an enabling social and policy environments regardless of their study areas. This could affect the study results as the participants from one study area might have an opportunity to come into contact with ASRH activities in another study area (Erulkar et al., 2004). While the study addressed this by controlling for a number of background factors as stated in the eligibility criteria, the results should be interpreted with these limitations in mind.

Another limitation was that since the questionnaire was developed based on the preliminary findings from the initial qualitative phase (in-depth interviews, observations, client exit interviews), some important issues that could have been investigated using quantitative methods were not included as they were uncovered in the later phases of the qualitative data collection. For instance issues of defilement/incest were not included in the questionnaire as it did not emerge during the initial interviews.

Further, other issues which were considered sensitive during the pre-testing of the research tools were removed from the questionnaire after noting the community concerns about such questions. For instance, questions linking time of initiation and sexual debut were dropped as they were considered sensitive and hence could affect the working relationships between Save the Children (organisation supporting the activities being studied) and the communities. However, qualitative data pertaining to the issue were collected.

As voluntary counseling and testing services were only present in few (four out of twelve studied) intervention health facilities, it was also impossible to assess the impact of YFRHS on utilisation of such services.

Poor quality of documentation in the health facilities also made it difficult to have a very clear picture of service utilisation in most facilities. For instance, most facilities had scanty information on SRH service utilisation by adolescents though the providers acknowledged the use of such services by unmarried adolescents. Moreover, lack of documentation on the marital status of the clients, actual age and instead using adult or child also made it hard to assess the use of the services by unmarried adolescents.

Another limitation of the study was lack of involvement of unmarried adolescents aged less than 13 years in FGDs and in-depth interviews. This was as a result of their non-participation in the data collection process due to their shyness to provide detailed accounts of what was being investigated. This means that their views were not represented in the qualitative results.

Lack of adequate clients for client exit interviews at the non-intervention health facilities who had come for SRH could also narrowed the understanding of the perspectives of the clients visiting non-intervention facilities.

Moreover, due to the familiarity of the investigator to the community, it was not easy for the investigator to take on a novice role especially in the clinical area. This could affect

the quality of data that could be collected. However, the use of checklist ensured that the investigator collected adequate data to address the research questions.

Lastly, this study was based on cross-sectional data, which implies that the direction of casual relationships cannot always be determined (Meekers and Klein 2002).

4.10 ***Conclusion***

From this chapter, it is evident that for a study to have valid results which would reflect the reality of the worlds being studied, consideration of epistemological and methodological stances should be spelt out clearly. Epistemology, theoretical perspectives, methodology and methods guided the whole research process.

Moreover, use of constructionist approach to understand unmarried adolescents' sex practices allowed a more subtle analysis of unmarried adolescent reproductive health and a more robust organisational analysis to understand attributes of demand (adolescents) and supply (YFRHS).

Chapter Five

The Socio-Cultural Contexts of Adolescent Sexual Practices in Malawi

5.0 *Introduction*

Adolescents live in communities in which cultural, religious and traditional influences are important motivators of behaviours for people of all ages. Adolescent sexual and reproductive practices occur in an environment of dynamic change and inconsistent social norms. This environment which influences human behaviours includes individuals, peers, partners, family and household, institutions and communities, policies and social norms (Adamchak et al, 2000). In most cases, the response to such influences varies between generations and societies. For some, this complexity provides opportunity and choice; for others, it means a struggle for survival. Considering this complexity of social determinants of sexual health, YFRH programme in Mangochi focused on individual, community, family, institutions and health facilities to improving knowledge, attitude and skills on SRH, increasing availability and accessibility of quality SRH services and improving social and policy environment for ASRH (Save the Children 2002).

Using social identity theories (Tajfel 1981; Tajfel and Turner 1986; Tarrant et al, 2001), this chapter explores how the social and cultural contexts affected SRH behaviours particularly sexual activity and adoption of SRH preventive measures (abstinence, condom use, having one sexual partner and contraceptive use) among unmarried adolescents in Mangochi. This chapter uses data from the survey, semi-structured in-depth interviews with unmarried adolescents, health workers and community elders, and focus group discussions conducted in both intervention and non-intervention areas. Insights have also been drawn from discussions with different respondents.

The first section explores the adolescent sex practices. The second section examines the medical and cultural faces of SRH problems. The third section presents the role of gender. The fourth section covers the socio-cultural factors affecting ASRH. Lastly, the chapter concludes that socio-cultural forces related to social identities had strong influences on sexual behaviours among unmarried adolescents.

5.1 ***Adolescent Sex Practices***

Adolescent subcultures related to sex and sexual relationships play a great role in sexual subjectivity and sexual behaviour. These subcultures appear to affect the sexual lifestyles, hence influencing their sexual life and their relationships.

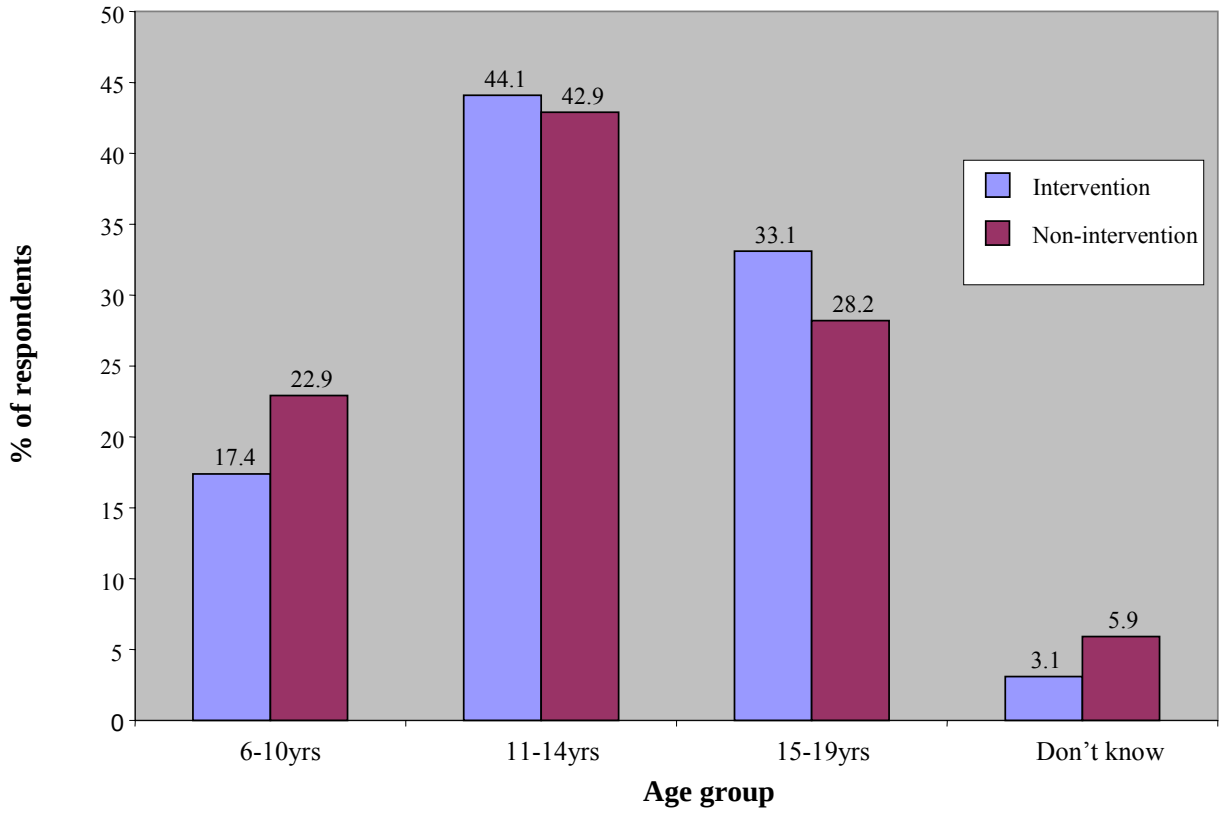
5.1.1 *Premarital Sexual Activity as Lifestyle*

Mangochi District had ambiguous cultures that defined sexual norms which unmarried adolescents were supposed to follow. While some norms prohibited premarital sex, other norms encouraged or forced the adolescents to have unprotected sex. Traditions, like the life transitions were marked by rites of passage that incorporated unsafe sex practices as part of the accepted cultural tradition. Besides, the traditions also associated sex with masculinity among males. Because the use of SRH preventive measures by the unmarried adolescents was a taboo, such traditions could increase the adolescents' vulnerability to SRH problems.

Although the no-premarital-sex culture acted as social control for adolescent sexual behaviours, unmarried adolescents followed the culture that promoted premarital sexual activity. This was reflected in the survey results that showed that despite the no premarital sex norms, 37.3% and 34.6% of the adolescents in the intervention (n=523) and non-intervention (n=491) areas respectively had had sex. Crucially, more male adolescents than female adolescents had had sex as 51.1% and 45.6% of male adolescents in the intervention (n=272) and non-intervention (n=272) areas respectively had sex experience; compared to only 32.3% and 21% of the female adolescents in the intervention (n=251) and non-intervention (n=219) areas respectively. Further analysis shows that statistically more male adolescents had had sex than female adolescents in both intervention (X^2=46.279, df=1, p=0.000) and non-intervention areas (X^2=32.392, df=1, p=0.000) respectively.

The study further showed that early sexual debut appeared to be the norm among those who were sexually active. This was reflected in the results as 44.1% and 42.9% of the adolescents in intervention (n=195) and non-intervention (n=170) areas respectively had their sexual debut at the age of 11-14 years (Figure 5.1).

Figure: 5.1 *Age at Sexual Debut among Unmarried Adolescents*



However, the survey showed the age at sexual debut among adolescents in the non-intervention areas was earlier than those in the intervention areas though there was no statistically significant difference (p=0.052). For instance, while the mean age at sexual debut in the non-intervention areas was 12.88 years (SD=2.64) and the modal age was 10 years, the mean age of sexual debut among adolescents in the intervention area was 14 years (SD= 2.53) and the mode was 15 years. Notably also, a remarkable proportion of adolescents had their sexual debut between 6-10 years in both areas (Figure 5.1), which also matched with the age of initiation ceremonies whereby '*kwita mauta'* (shake off dust) was encouraged.

The study also revealed that age at sexual debut varied by sex. While more males started having sex at 6-10 years, more females had it at 11-14 years. However, at other age categories, more females than males started having sex in both intervention and non-intervention areas (Table 5.1).

Table 5.1 *Age at Sexual Debut by Sex*

Age categories (years)	**% in Intervention Area**		**% in Non-intervention Area**	
	Male	Female	Male	Female
6-10	18.7	14.3	26.6	13
11-14	35.7	47.5	40.3	50
15-19	29.5	42.9	28.2	28.3
Don't know	4.3	7.1	4.8	8.7

However, Table 5.1 shows that higher proportions of adolescents had their sexual debut earlier in the non-intervention areas than in the intervention areas. Further analyses also shows that while the mean ages for sexual debut for male and females were 13.7 years (SD=2.6) and 13.9 years (SD=2.5) respectively in the intervention areas, males and females in the non-intervention areas initiated sex by 12.7 years (SD=2.8) and 13.3 years (SD = 2.2) respectively. However, statistically, there was no significant difference in the sexual debut among male and female adolescents between the intervention and non-intervention areas.

The qualitative results however revealed that more male adolescents started having sex earlier than female adolescents because unlike females, boys were forced to have "*kwita mauta*" (shaking off dust) soon after initiation ceremony while in girls, this was forced when they had started menstruation.

> We were told to have sex within seven days after coming out of the initiation camp. The *Chitonombe* told us that we will be punished during the next initiation camp if we fail to have "*kwita mauta"*. Some also said that if we fail, our parents will die (Newly-initiated boy, 8 years, Intervention Area 2).

The study also found that age at sexual debut varied by schooling status. The results showed that 58.2% and 55.5% of males and females respectively who were in school had their sexual debut between 10-15 years. In comparison, 69.2% of males and 84.6% of females who were out-of-school initiated sex by 10-15 years. Thus, more out-of-school adolescents initiated sex earlier than those who were in schools.

Other evidence from the study showed that females who were known to say 'no' to male sexual advances were targeted by boys to have intercourse with them. Thus, girls who decline to engage in sexual activities with males set themselves up as targets for

penetrative sex from males seeking affirmation of their masculinity. In certain instances, males could use whatever power they had- financial, material or even coercion- to induce the girls to have intercourse with them so as establish and display their masculinity among their peers (see also Jaffray 2006).

The study revealed other social beliefs and attitudes that also encouraged sexual activity among adolescents. For instance, while girls acknowledged that they could refrain from sex, they felt that this was not practical for boys. As a result of such society's beliefs and attitudes, the Malawian culture in the study area was more tolerant of risky male adolescent sexual behaviours or may even encourage it. Besides, such beliefs and attitudes also influenced some girls' response to their boyfriends' sexual advances

> For girls it is easy to refrain from sex but it is difficult for boys. Boys cannot stay for three to five days without sex. They always need to have girl-friends to have sex with. So girls may give in to their boyfriends in order to keep them away from having sex with other girls (Female Adolescent, 15 years, Intervention Area).

Furthermore, sexual activity was traditionally considered a sign of a normality of the individual which could not be resisted. One elder expressed

> Sex is a sign of normality of the human beings. Young people need to do sex to show that they are normal. If no rumour about one's sexual life is heard, the parents of such a child become concerned whether their child is sexually healthy (Male Adult, Intervention Area 3).

However, as unprotected sex was the norm, this increased the vulnerability of adolescents to SRH problems. Additionally, while premarital sex was not approved by the traditional and religious leaders, evidence was common that some custodians of these social norms had sexual intercourse with the unmarried young girls in the society. Some anecdotal and press reports for instance show that some religious leaders have sex with young women (See Annex 19). This clearly showed the double standards of the religious leaders.

Lastly, although the premarital sex was prohibited socially and theoretically, those adolescents who were not involved in such sex were stigmatised. Such adolescents especially boys were given names "*wokungwa mupapaya*" (meaning someone who is

weak and falls from a pawpaw tree) or "*gojo*" (barren). In some instances, some community members including the elders described such adolescents as being abnormal

> It is not normal for a normal human being to live without having sexual intercourse. If a boy shows such behaviours, it is advisable for his/her parents to sit down with him/her and ask his/her problem (Female Adult, Non-intervention Area 3).

Because of the fear of such stigma, most adolescents were involved in sexual activity in order to prove the sexual normalcy.

Overall, the ambiguous sexual norms and stigma associated with sexual behaviours encouraged the unmarried adolescents' adoption of unsafe sex practices that increased their vulnerability to SRH problems.

5.1.2 *Multiple Partners as Sign of Masculinity*

Multiple sexual partnerships were associated with high social status among males and beauty among females in the research area. Due to this attitude, 66.2% and 69.4% of the sexually active adolescents in the intervention (n=195) and non-intervention (n=170) areas respectively had more than one sexual partner. Further analysis showed that the mean number of partners in the intervention areas was 1.65 (SD=0.479) and 1.68 (SD=0.468) in the non-intervention areas. However, the difference in the proportions between the two areas was statistically insignificant (p=0.529).

Although the results showed that adolescents who were sexually active in both areas had multiple sexual partners (see above), the results showed that more males had multiple partners than females in both areas (Table 5.2).

Table 5.2*: *Number of Sexual Partners by Sex and Area

No. of Partners	**% in the Intervention Area**		**% in the Non-intervention Area**	
	Male (n=139)	Female (n=56)	Male (n=54)	Female (n=116)
One Partner only	27.34	50	30.86	18.97
More than one partner	76.66	50	81.03	69.14

Statistically, it was noted that significantly more male adolescents than females had multiple sexual partners in both intervention (Fisher's Exact test X^2=16.053, df=1, p=0.001) and non-intervention (Fisher's Exact test X^2=17.375, df=1, p=0.001) areas. These findings demonstrated the accuracy of the stereotype of masculinity that

encouraged sexual activity and multiple sexual partnerships among males. This stereotype of having multiple sexual partnerships as a badge of masculinity and social achievement among males was general normalised in the society

> It is normal for males to have more than one sexual partner. That shows that they are real men. […] Girls should however have only one boy-friend, otherwise people will think that they are not properly brought up by their parents (Female Adolescent 19 years, Intervention Area 3).

Thus, while the social norms discouraged premarital sex, the dominant masculinity shaped and encouraged multiple sexual partnerships among male adolescents. However it was noted that while multiple sexual partnerships was generally a sign of prostitution among young women, young women who had multiple male sexual partners were viewed as being beautiful.

> You will see that beautiful girls have many boyfriends. Sometimes, boys fight for them because of their beauty (Male Adolescent 17 years, Intervention Area 1).

Such attitudes encouraged young men and women to have multiple sexual partners. In some instances, it was observed that where some girls had no or few male sexual partners, such girls could easily give in to sexual advances from boys or men in order to prove to their peers they too were beautiful. Thus, because of community attitudes towards signs of beauty, some young women opted to have multiple partners as that symbolized that they were attractive to males. However, these social identities could increase the adolescents' vulnerability to SRH problems. This could be worsened by the fact that use of protective measures, like condoms, was associated with lack of love, trust or infidelity and hence this culture increased the risk of SRH problems. These findings demonstrated the social stereotype of masculinities and femininity that encouraged young men and women to have multiple sexual partners, but yet not adopt safe sex practices

Apart from the local constructs of masculinity and femininity, other girls had multiple sexual partners for other reasons including a source of livelihood

> Some girls depend on what they get from their sexual partners: soap, clothes and money. So they have many sexual partners to get enough support for their living (Male Adolescent 18 years, Intervention Area 2).

Thus, the social identities associated with multiple sexual partnerships influenced unmarried adolescents in the adoption of unsafe sex practices. However, other social factors such as poverty also encouraged girls to have multiple sexual partners.

5.1.3 *Boy-Girl Relationships: Mini-Marriages?*

While premarital sex is prohibited, boy-girl friendships were acceptable and evidence from the qualitative results showed that sexual activity between male and female adolescents were common. The study found that many people in the community objected to sexual relationships between males and female adolescents as it was being equated to '*mini-marriages*' due to the way such partners behaved in their relationships

> Young people believe having a boy or girl friend is almost having a mini-marriage. They do have sex (Male Adult, Intervention Area 2).

The results from adolescents also showed that heterogenous relationships meant that partners had to have sexual intercourse

> If you have a boyfriend, it is difficult to abstain. Your partner will force or induce you to have sex. If you want to refrain from sex, then be single. If you are single, you can be able to abstain from sex unless if boys or men rape you (Female Adolescent, 19 years, Intervention Area 3).

Although sexual activity was common in boy-girl relationships, the use of safe sexual practices varied. The study found that fewer adolescents who had regular boy/girl friends abstained from sex while those who had more than one sexual partner used condoms and contraceptives (Table 5.3).

Table 5.3*: *Having Regular Sexual Partner and Safe Sex Practices

	Primary abstinence		*Secondary abstinence (past 6 months)*		*Have one sexual partner only*		*Condom Use (past 6 months)*		*Currently Contraceptives*	
	INT	NON	INT	NON	INT	NON	INT	NON	INT	NON
Have regular boy/girl friend										
Yes	13.0*	20.0*	43.8*	44.6*	44.9	35.0	38.0*	0.4h	21.3**	14.3k
No	73.4	72.5	79.8	78.1	22.8r	25.0	9.6	12.3	6.1	2.6

* p=0.000, h (p = 0.004), ** (p = 0.002), k (p=0.006), r (p =0.0.002)

Further analyses revealed that more adolescents with regular partners were significantly using contraceptives in both intervention (X^2 = 9.90, df = 1, p = 0.002) and non-

intervention (Fisher's exact test $X^2 = 8.43$, df = 1, p = 0.006) areas. However, while more adolescents with regular partner significantly used condoms in the intervention areas ($X^2 = 22.378$, df = 1, p = 0.000), significantly fewer adolescents with regular partners did so in the non-intervention areas ($X^2 = 8.230$, df = 1, p = 0.004). While lack of availability might have contributed to low use in the areas, in-depth interviews showed that identities associating condom use with prostitution played a part in the non-intervention areas

> Adolescents avoid condoms. If one sees that a boy or girl has condoms, people always think you go about and have sexual intercourse with different people. Unlike in areas such as --- (names withheld) where communities are taught about sexual health for young people, people here do not appreciate the importance of condom use (Female adolescent 18 years, Non-intervention Area 3).

Beside, Table 5.3 shows that having a regular sexual relationship was associated with higher proportions of adolescents with only one partner. It was learnt that adolescents in regular relationships were more confined to the one partner while those with no regular partners have more partners in search for a future marriage partner

> Girls who are not sure of the man they would marry in future go on searching until they get one. […] They may be involved in several sexual relationships as they are not sure of the one who can marry them (Female Adolescent, 17years, Intervention Areas 2).

However, unlike in the non-intervention areas, significantly more adolescents with regular partners in the intervention areas had just one sexual partner than those without regular partners ($X^2 = 9.674$, df=1, p= 0.002). Other respondents attributed this behaviour to lack of counselling by the communities or parents on the impact of the behaviour on ARH in the non-intervention areas. As stated earlier, due to lack of awareness on the dangers of such practices in these non-intervention areas, having multiple partners was still considered as a social achievement.

Notably, Table 5.3 indicates that significantly more adolescents who never had a regular partner practised primary abstinence in both intervention ($X^2 = 118.185$, df = 1, p = 0.000) and non-intervention ($X^2 = 72.324$, df = 1, p = 0.000). Similarly, among those who had ever had sex, more adolescents who had no regular sexual partners significantly abstained from sex in the past 6 months in both intervention ($X^2 = 26.873$, df = 1, p = 0.000) and non-intervention ($X^2 = 18.996$, df = 1, p = 0.000). These results point to the fact that

having romantic relationships appeared to reinforce sexual activity among unmarried adolescents.

Although the social norms prohibited sexual relationships as they were thought to encourage premarital sex in theory, other traditional forms of sexual relationships such as '*chitomero*[9] and '*chisuweni*[10]', allowed the male and female partners to have sexual intercourse without any reprimand from the community or parents. Moreover, such tradition disempowered girls from controlling their sexual lives. Boys could have sexual intercourse with girls without any questioning from the girls themselves, their parents or the society because the two were socially considered prospective '*husband*' and '*wife*' and hence could have sex

> Traditions like '*chitomero*' encourage our girls to start having sex with prospective husbands without any questioning from the girls or parents or marry at very young age sometimes against their parents' wish. Some girls have become pregnant during this period (Female Adult 16 years, Intervention Area 4).

Similarly, in the tradition locally known as '*chisuweni*', whereby cousins could have sexual intercourse or even marry, cousins were socially encouraged to associate with each other sexually by their parents and the society. Because of this social expectation, adolescents especially girls could hardly resist sexual advances from their male cousins

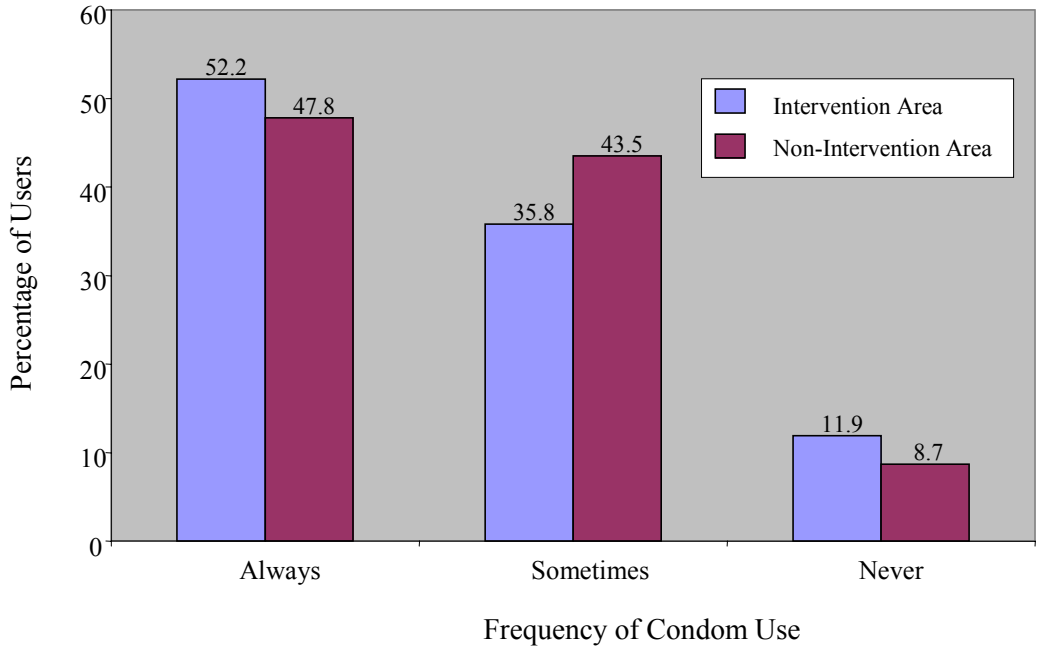
> Females can rarely say 'no' to sexual advances made by their male cousins as parents wouldn't be harsh on them even if they hear that they had a sexual affair […] The society would also call cousins who resist their cousins' sexual advances as being rude because they consider them as potential husbands and wives (Female Adolescent FGD, Intervention Area 4).

Although some adolescents reported using preventive measures like condoms in such sexual relationships, the frequency of their use was inconsistent. Among those who had sex in the past 6 months, for instance, only 52.2% and 47.8% of condom users in the intervention and non-intervention areas respectively used it in all sexual intercourses (Figure 5.2).

[9] Chitomero is a traditional arrangement where a boy and a girl who agree to marry in future were allowed to have sexual relationships

[10] Chisuweni means cousins; but here means sexual intercourse socially allowed between male and female cousins

Figure 5.2*: *Frequency of Condom Use among Unmarried Adolescents in the Past 6 Months



Moreover, the study found that while some adolescents reported to have used condoms at the start of sexual relationships, most of them rarely used them when the relationships progressed because it was socially believed that condoms should be used with people you did not trust or were not familiar with. In this case, if you are familiar with the partner, condom use was unnecessary as another participant explained

> Condoms are often used when you have just started your relationships. […] Condoms are used on someone who you are not familiar with or whom you do not trust. But after several encounters, you build trust in each other and then continue to have sex without condoms (Boy/girls FGD, Non-intervention Area 1).

Other evidence from the study also showed that the social construction of some SRH conditions was barrier to ARH promotion. For instance, many young people had unprotected sex because they believed that HIV/AIDS was a condition affecting older people

> *Interviewer*: You said that you do not use because you have trust in each other, has either of you been tested for HIV?
> *Respondent*: No, I think my boy-friend has no HIV and I don't have.
> *Interviewer*: What gives you the courage and assurance to say so?
> *Respondent*: That disease mostly is common among old people. People who die of it are old. No young person is so far known to have died from it in our area.
> (Female Adolescent 17 years, Intervention Area 2).

Thus the social construction that HIV/AIDS was a condition of the old people hindered some adolescents from adopting safe sex practices.

Besides, some myths and misconceptions surrounding condoms and their use also discouraged some adolescents from using condoms. Some young men for instance believed condoms were porous; they could burst easily, while others especially boys objected to condom use because they thought it disrupted their performance and pleasure during sex

> Girls undermine boys if they have not ejaculated enough semen during sexual intercourse. As such, using condoms can even worsen the situation as girls would feel as if their partners are not 'real' men at all (Extract, Male FGD 1, Intervention Area 3).

Similar observations were also made in the non-intervention area that showed that most boys were not using condoms as they feared being described as impotent by their female partners if they had not ejaculated their sperms into the women's vagina.

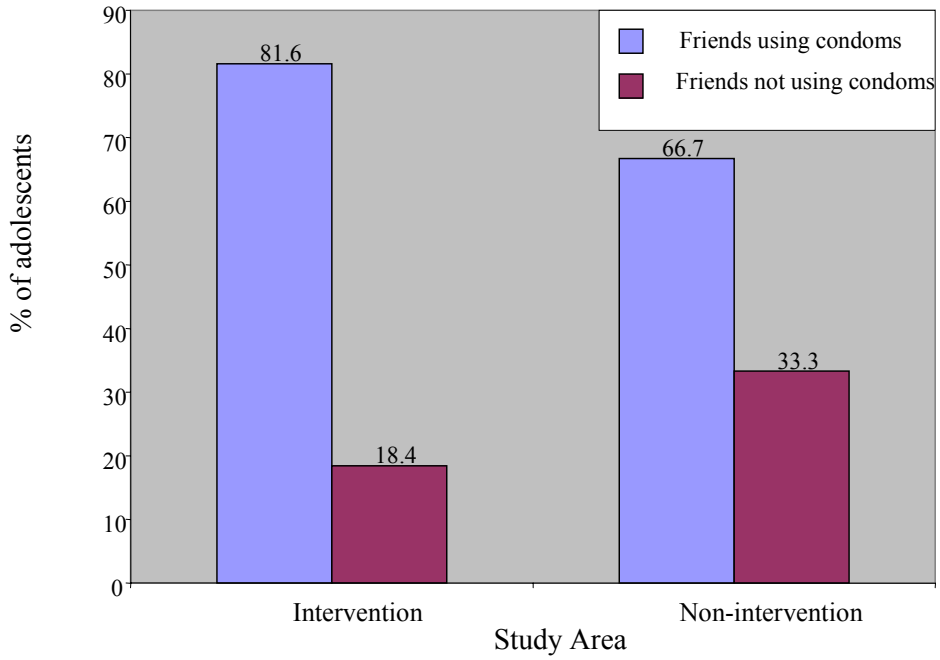
> Girls describe a boy's performance based on ejaculation. If you fail to ejaculate, girls will talk about you when they are playing. They give you different names – "immature pawpaw tree" or "someone who fell from a pawpaw tree". This makes more boys to avoid using condoms (Male Adolescent 15 years, Non-intervention Area 1).

Similarly, many of the objections to condom use reported by girls were also related to ideas of sexual pleasure. Both sexes used similar terms like '*eating a sweet with a wrapper on*' or '*wearing a rain-coat when bathing*' to describe the problems of condom use during intercourse. As a result, some sexually active adolescents had sex without using a condom thereby exposing themselves to STIs including HIV/AIDS and early pregnancies.

On the other hand, while other safe forms of sex practices such as touching and mutual masturbation could help in prevention of SRH problems, all adolescents who practised them saw them as prelude to penetrative sexual intercourse. Moreover, from the results it was clear that sex meant vaginal intercourse and it was this that was equated with 'real' and 'normal' sex.

As adolescents tended to imitate their peers' behaviours in an effort to match the group behaviour (identity construction) or to show others that they were able to do what the peers were doing, peer influence could affect ASRH promotion. For instance, it was observed that 64.3% and 45.5% of those adolescents who had had sex in the intervention and non-intervention areas respectively reported having peers who were also having sex; while only 39% and 34.4% of those who ever had sex in the intervention and non-intervention areas respectively said had no peers who were involved in sexual activity. Similarly, more adolescents who reported having used condoms in the past six months had peers who were also using condoms (Figure 5.3).

Figure 5.3**:** *Peer Influence and Condom Use Among Adolescents in the Past 6 months*



Further analysis also revealed that significantly more adolescents whose peers were using condoms also used condoms in the past six months in the intervention areas ($X^2 = 6.813$, df =1, p = 0.009).

Overall, these results mean that unless the adolescent culture on sex practices is transformed, such culture could perpetuate SRH problems among unmarried adolescents.

5.2 *The Medical and Cultural Faces of SRH Problems*

Sexual and reproductive health problems have different images in the Malawian societies. The study observed that SRH problems had medical and cultural images which were shared by all society members. For instance, while early pregnancy was a health risk for young people within the medical constructions; pregnancy was constructed as a sign of potency and fertility in young people. It also raised social status of young people

> When girls become pregnant, they are respected in the society. […] Boys who impregnate girls are also seen as real men in the society (Male Adult, Non-intervention Area).

Besides, pregnancy was also used as a badge of womanliness in the society. As such, though premarital sex was prohibited, most societies emphasised that importance of childbearing if girls were to be recognised in the society as women. This in a way reinforced early pregnancies among young people. Due to these cultural constructions of pregnancy, use of contraceptive methods including abortions by young people was not acceptable in the society regardless of their ages and the reasons for their actions. In most societies, pregnancy was seen as a gift from God that could not be avoided. Other evidence also showed that most girls who became pregnant were not advised by their parents or community members to visit antenatal clinics unless if they had some pregnancy-related problems.

> Most girls who become pregnant only visit the health facilities if they are in doubt that they are pregnant. Once they are sure, they never visit the clinics again until the time for delivery comes. […] But most of them come when they have complications like vomiting while pregnant or are anaemic (Health Worker 2, Intervention Facility 3).

Likewise, while STI was considered as a pathological condition, the cultural construction viewed it as a sign of manliness among male adolescents.

> A real man should show his manliness that he has had sexual intercourse with different women. […] Apart from pregnancy, STI is one of the manifestations of manliness in our society (Male Adolescent, 17 years, Intervention Area 2).

Due to these attitudes, most boys opted not to have protected sex as the contraction of STIs raised their self-esteem and social status among their peers and the whole community.

On the other hand, while HIV/AIDS was viewed by everybody as a fatal condition that was preventable and transmitted through sexual intercourse among others, the cultural constructions of the disease gave it a different meaning. Among the religious people, HIV/AIDS was seen as a plague given by God due to people's sins. Other people viewed it a health problem fore-ordained by God or originating from ancestral spirits due to people's immoral sexual behaviours. As such, it was believed that HIV/AIDS could not be avoided or prevented.

> HIV/AIDS is from God. Even if you always use condoms, you can still get it if God fore-ordained that you will die from HIV/AIDS (Female Adolescent, 16 years, Intervention Area 4).

However, while community members embraced both the medical and cultural views of SRH problems they trusted more on the latter. This had implications for health promotion. For instance, these beliefs had been associated with high levels of use of traditional health care system as the primary source of health care for SRH problems. Among others, this was so due to the fact modern health care provides some services like contraceptives including condoms which was against the social norms for unmarried adolescents. These services (contraceptives) were seen as promoting sexual activity among unmarried people.

Overall, the variations and tensions between the medical and cultural images of SRH problems had effects on ASRH promotion because such variations influenced health seeking behaviours. Moreover, in most cases, local people perceived some SRH issues as conditions which could not be prevented or where they could not be in control over their occurrences.

5.3 *Gender as the Fulcrum for Social Control and Subservience*

Culture is an important determinant of the socialisation process of young people in Malawi. Entrenched in the whole process of socialization are cultural values that tend to emphasize and strengthen the dominance of males and insubordination of females in sexual relationships. For instance, from a very young age, while girls are taught about their submissive roles in sexual relationships, boys are taught about their lead role. Female adolescents are often taught to leave sexual initiative to their male partners and to behave in ways that will please their male partners.

Moreover as there were social attitudes that '*amuna ndi ana*' meaning that 'males are children who do not think properly', girls were socialised and treated as adults and ready-made sexual beings. They were also told to respect their male partners' sexual wishes as males were like 'children'. Because girls were treated like adults soon after puberty, they were forced to behave according to their social expectations in order to maintain their social identities. For instance, Yao girls were advised not to fear a man (see also UNESCO 1996). As such, girls could challenge older men to have sex with them despite their young ages. Moreover, because of the communities' attitudes towards males as 'children', community members including females accepted the boys' behaviours including having forced sex.

While premarital sex was theoretically prohibited, traditions allowed sexual activity among unmarried boys. For instance, as masculinity was manifested through sexual activity, boys were encouraged to have sex. In some instances, it was reported that parents were not ashamed or angry if their sons had impregnated other girls. Instead of rebuking their sons, phrases like *"Look, our son is a real man not like the rest of you. He has shown his prowess on Mr. so and so's daughter"* (Male Adult, Intervention Area 1) were common among parents whose sons impregnated other people's daughters at one time.

Moreover, due to the belief that having multiple sexual partners was a badge of social status, young men were socialised to date as many girls as they like before deciding on marriage. By contrast girls were only expected to have one boyfriend before marriage and anymore than that number, girls were described as 'loose' or 'whores'(se also Phiri 1998). Girls who had sexual partners were in some societies forced into early marriages in order to protect them from out-of-wedlock pregnancies which would damage the reputation of their parents (see also Stewarts et al., 1998; Phiri 1998).

Cultural norms that expected females to be inexperienced and naive in sexual matters and to see themselves as passive receptacles of males' sexual passions were widely held in the society. Sexual activity was male dominated and controlled. As such, girls were powerless to refuse sex or negotiate safe sex. In fact, if a girl initiated sexual intercourse, she was labelled a prostitute. Because of this male dominance in sexual relationships, most girls

claimed to have been persuaded to have sex by their boyfriends though the majority of girls said they felt loved if asked for sex by their male partners (see also CSR 1997; Kaler 2003). However, the survey results showed that adolescents who discussed sexual matters with their sexual partners were more likely to have used condoms and were currently using contraceptives in both intervention and non-intervention areas (Table 5.4).

Table 5.4: *Sexual Partner Communication and SRH Behaviour Adoption*

Variable	Primary abstinence		Secondary abstinence (past 6 months)		Have one partner only		Condom Use (past 6 months)		Currently using Contraceptives	
	INT	NON	INT	NON	INT	NON	INT	NON	INT	NON
Discussed Sexual issues with partner					*		**	*	*	***
Yes	8.1	11.3	51.0	40	25.0	24	38.8	37.5	22.	10.0
No	13.1	15.6	70.3	70	48.8	37	14.6	12.5	8.	4.7

*p=0.001, ** (p=0.000), ***(p=0.006)

Further analyses indicated that more adolescents who could discuss sexual matters with their partners significantly used condoms in the past 6 months in both intervention (X^2 = 27.062, df =1, p = 0.000) and non-intervention (X^2 =7.456, df = 1, p = 0.006) areas.

Similarly, more adolescents who could discuss sexual matters were significantly using contraceptives in the intervention (X^2 =10.821, df=1, p = 0.001) and non-intervention (Fisher's exact test X^2 = 9.044, df=1, p=0.006) areas. Among others things, such discussion empowers the partners to negotiate for the use of safer sex practices

> If you can open up on sexuality issues with your partner, it becomes easier to negotiate for safer sex. You can suggest condom use, but if there is no such atmosphere in your relationship, you may fear doing so despite knowing their benefits (Female Adolescent, 18 years, Intervention Area 4).

However, the survey results showed that fewer adolescents who discussed sexual issues with their partners practised primary and secondary abstinence and had one sexual partner (Table 5.4). Statistically, it was found that significantly more adolescents who never discussed sexual issues with their partners had one sexual partner in the intervention areas (X^2 =10.773, df=1, p = 0.001).

Among other issues, female FGD results revealed that discussing sexual matters between adolescents of opposite sex could predispose females to SRH risks because such

discussions opened up opportunities for males to start negotiating for sex. This observation also concurred with an in-depth interview result

> If a girl shows a smile when a boy is talking about sex, the boy assumes that the girl is interested and may press to have sex with her. […] If a girl shows annoyance when a boy is talking about it, the boy can't propose to have sex with you even if he had such a thought (Female Adolescent, 16 years, Non-intervention Area 4).

Some boys however perceived girls who discussed sexual matters with them as a sign that they girls were interested in having sexual intercourse with them. Thus, social construction of openness on sexual issues encouraged boys to initiate sexual intercourse with the girls they had discussion with.

Besides, the socialisation which increased economic power of male adolescents as they were encouraged to do productive work (paying jobs) while females to assist with non-paying household chores (reproductive roles) (Moser 1993), reinforced females' dependence on their male sexual partners for financial and material support. This culture reinforced male control and female subordination in sexual issues as females acted to please their male partners so that they could provide their needs.

The study also found that the culture reinforced subservience among females in heterosexual relationships. The female adolescents for instance were socialized to serve the male partners as their masters. The girls therefore could not to oppose any sexual actions suggested and taken by their male partners, despite their awareness of health threats such actions could have. Thus, the females had no choice to exert their power in sexual decision-making. This was also reflected in the survey results that showed that though 12.8% and 10.4% of adolescents in the intervention areas (n=523) and the non-intervention areas (n=491) respectively said they could ask their sexual partners to use safe sexual practice, only 22% and 24.3% of those who said could do so in the intervention (n=110) area and non-intervention (n=26) areas respectively condoms were females. This was attributed to gendered roles of females pertaining to sexual issues as the suggestion to use condoms was expected to be the male's responsibility in the study area.

> It is not my responsibility to ask my boy-friend to use condoms. We can use it if he wants to use them. If he can't suggest condom use, then we cannot use because it is his responsibility (Female Adolescent, 16 years, Intervention Area 3).

The implications of these gendered roles associated with condom use were also reflected in the survey results that revealed that more male adolescents than female adolescents who had sex used condoms. Thus, the survey results showed that among sexually active adolescents, 79.5% and 87.5% of those who used condoms in the last 6 months prior to the study in the intervention (n=195) and non-intervention (n=170) areas respectively were boys; and only 20.5% and 12.5% of adolescents who used condoms in the intervention and non-intervention areas respectively were girls.

Apart from the condom use, sexually active males also influenced the adoption of some SRH behaviours in heterosexual relationships. The table below shows that more male adolescents who were sexually active influenced their female partners' use of non-condomised contraceptives or reported secondary abstinence in the past 6 months (Table 5.5).

Table 5.5: *Proportion of Adolescents Adopting Safe Sexual Practice by Sex*

Demographic Variables	**Secondary Abstinence (past 6 months) (%)**		**Current Contraceptive Use (%)**		**Having One Sexual Partner (%)**	
	INT	NON	INT	NON	INT	NON
Sex		***			**	**
Female	26.8	19.6	10.7	4.3	53.9	53.5
Male	38.1	37.9	12.9	7.3	32.4	30.3

*p=0.000, **p=0.001,*** (p=0.024)

Further analysis revealed that significantly more male adolescents in the non-intervention areas than females practised secondary abstinence in the past 6 months (X^2=5.108, df=1, p=0.024). Other qualitative results revealed that this was due to the fact that sexual initiation was done by the male partner in heterosexual relationships in the study areas. As such, if the boys intended to refrain from sex, it was possible for both partners to do so.

However, the study showed that more female adolescents than males had one sexual partner and adopted primary abstinence. Statistically, more female adolescents than males had one regular sexual partners in both intervention (Fisher's Exact test X^2=16.053, df=1,

p=0.001) and non-intervention (Fisher's Exact test X^2=17.375, df=1, p=0.001). This could be due to the influence of cultural norms that associated with multiple partnerships as a social achievement among males in the society.

Other evidence however showed that girls who suggested using condoms during sexual intercourse were considered as prostitutes.

> How can a girl tell me to use condom? I can terminate the relationship with such a girl. She must have many sexual partners that's why she so experienced and courageous enough to tell me what to do (Male adolescent, 17 years, Non-intervention Area 1).

Thus, while the girls who could suggest the use of SRH preventive measures like condoms were considered as whores, similar behaviours by male adolescents were acceptable. Although socially it was expected that males had to initiate safe sex practices, most boys however more often talked about promotion of safe sex being the girls' responsibility.

> Girls are supposed to initiate safe sex because they are the ones who can become pregnant. […] The girls are the ones on the receiving end. *(Interviewer asked a question on STI and HIV prevention).* Oo yaaah, both boy and girls can contract STI or HIV, but the boy cannot become pregnant hence the girl should take a lead role (Male FGD, Intervention Area 3).

Overall, culture that promotes unequal power dynamics in sexual relationships and homosocialisation[11] plays a significant role in shaping and influencing sexual behaviour of adolescents in Malawi. This gender asymmetry could lead to increased adoption of unsafe sex practices that might affect ASRH promotion.

5.4 ***Socio-Cultural Factors and ASRH***

5.4.1 *Transition to Adulthood Rituals: 'Jando' and 'Nsondo'*

Initiation ceremonies were the important rituals conducted to mark transition from childhood to adulthood in Mangochi. '*Jando*[12]'and '*Nsondo*[13]' were used for males and females respectively. These ceremonies were an important component in the process of

[11] Homosocialisation is described as the way in which boys and girls are socialised differently as homosocial group (Gagnon and Simon 1974)
[12] Jando was male initiation ceremony where circumcision was done
[13] Nsondo was female initiation

socialisation in the society. During such ceremonies, young people with ages ranging from five to nine years were taught on the traditional norms related to sexuality and reproduction (Figure 5.4).

Figure 5.4: *Traditional counsellor advising female initiates*

The initiates, especially girls, were also counselled on good manners, respect for elders, their prescribed roles in the society and also on how to take care of themselves when they attained puberty.

The study however found that there were ambiguities and gender asymmetries in the process of initiation. For instance, it was observed that while the social norms prohibited premarital sex, initiation rites promoted premarital sex as part of transition passage rites. The newly initiated boys and girls were encouraged to have sexual intercourse soon after initiation, a ritual locally known as *kusasa fumbi or kwita mauta or kwita mesi* (shaking off dust) to mark their maturity. In most societies, such traditions were reinforced by informing the initiates that those who would not conform would be dooming their parents to die. These acts not only exposed young boys and girls to STIs including HIV/AIDS, but could also lead to teenage pregnancies and eventual drop out from school. Moreover, while the society disapproved of sex and SRH education in schools, public meetings or media, initiation ceremonies provided sex education to initiates. However, because the traditional counsellors had inadequate knowledge of the SRH issues, most of them

provided wrong information. For instance, it was learnt that some counsellors taught initiates that HIV/AIDS affected older people. This could affect adolescents' initiative for HIV/AIDS prevention.

While female adolescents were taught the cultural notion of being obedient and subservient to men and elders, the power to refuse sexual advances or negotiate for safe sex was not inculcated into them. Unlike boys, girls were taught to participate in sexual activity without questioning or suggesting anything while male adolescents were taught to control the sexual activity. Moreover, unlike male adolescents, females were taught to be modest and to avoid male company, not to master the dynamics of conversation and social interactions between males and females. Thus, female submission in every way to their male partners was emphasised.

> We are advised to be quiet when dealing with sexual issues. If you talk a lot, people may think you are sexually immoral and that stigma may affect your future prospect of marriage (Female FGD 3, Non-intervention Area 2).

Besides, although premarital sex and having babies outside wedlock were unacceptable to the society in theory, messages like 'adulthood is associated with being capable of engaging in sexual intercourse, bearing and rearing children and managing family affairs' were passed to the girls.

Alongside initiation ceremonies were traditional night dances locally known as '*Manganje*' that also influenced unsafe sex practices. Among others, traditional leaders advised people that such ceremonies were for enjoyment and hence people should be free to associate with any other person in any way desired including having sex. However, evidence from the health facilities revealed that such periods were associated with increased STI cases among the population, including adolescents

> We have many STI cases from October to December following initiation ceremonies. It may be because most people spend most of the time out – participating in the *Manganje* dances and possibly having sexual relationships with different people (STI service provider, Intervention Facility 1).

Thus, initiation ceremonies exposed adolescents to unsafe sex behaviours.

Notably, however, the study established that in areas where ASRH interventions used interactive techniques such as discussions and debates that aroused questioning of the culture and involved gatekeepers, adolescents and parents, there were changes made to the initiation ceremony practices that could promote ASRH.

> In areas where campaigns and discussions have been done and where the traditional leaders and the community were involved, some social norms have changed. People are sending their boys to the hospitals for circumcision instead of the traditional circumcision where one blade is used to circumcise all initiates. […] People have stopped passing on olden advice which encouraged *kwita mauta* and use of obscene languages. They are now taught about the importance of school and HIV protection (Initiation Counsellor 2, Intervention Area 1).

Thus, ritual initiation ceremonies increase adolescents' vulnerability to SRH problems. However, the evidence showed social change has potential to reduce such vulnerabilities.

5.4.2 *Cleansing Rituals: 'Fisi' and 'Kukutula Ngonji'*

Apart from the initiation ceremonies, other rituals such as '*fisi*' and '*kukutula ngonji*' were also common in the society. *Fisi* was a practice that used to happen when girls reached puberty. During this ritual, young girls were instructed to have sexual intercourse with a chosen older man in the society who was named '*fisi'*, literally meaning 'hyena' with the aim to cleanse the dirt associated with the girls' first menstruation. To reinforce the practice, girls were threatened with the occurrence of a misfortune such as having a scaly body (locally known as '*kutuwa'*). In most cases, consent was not sought; and parents and community just arranged the ceremony without the girls' awareness and the men could come when the girls were asleep at night.

Besides, young girls were also used in cleansing rituals following the death of someone's wife. In this ritual, the widower had sex with young girls, in ritual commonly known as "*kukutula ngonji"* (literally meaning house cleansing marking social acceptance that the widower can start having sex with other people) and the person used for the process was called "*litunu*" literally '*hyena*' or a '*thief*'. Because young women were used, this increased the girls' risk of STIs including HIV/AIDS and pregnancy. The acts did not only promote the sexual abuse of children and put the health of the girls at risk, but they also violated the right of girls to free choice which is inherit in human beings as stipulated in the Malawi Constitution (Malawi Government 2004).

Although such practices were a symbol of social identity in some tribes, evidence from some areas where discussions were done on the impact such practices could have in the face of HIV/AIDS showed some changes that could reduce the SRH risks associated with the rituals

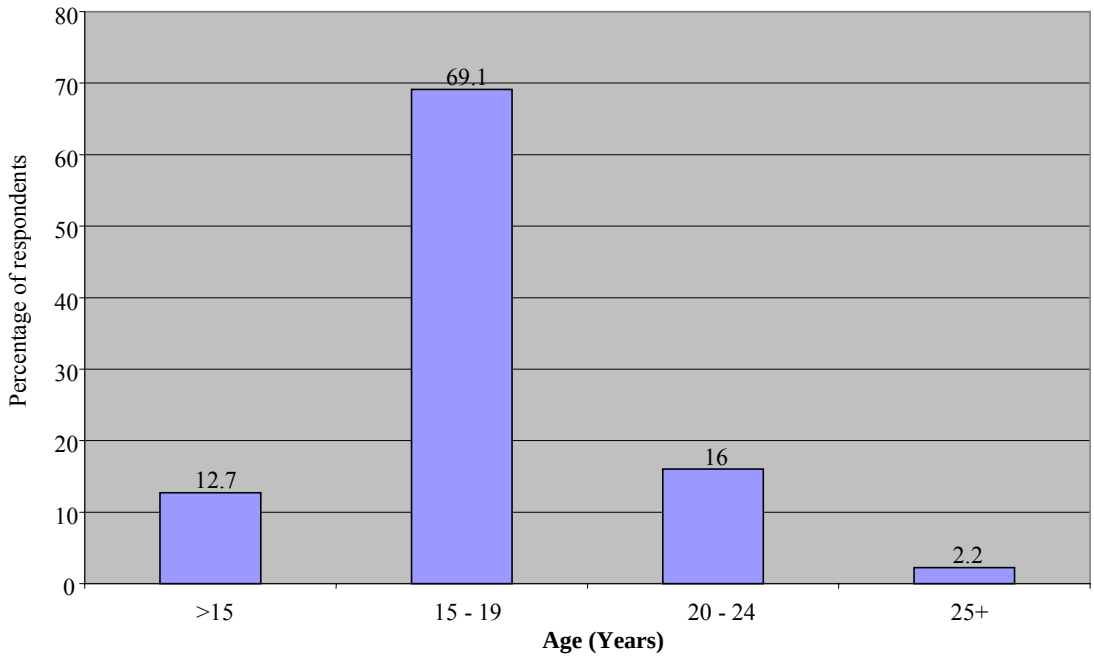
> We used to have death cleansing rituals where the widower used to have sex with a young girl. Few communities still practise it now. We now recommend that traditional herbs be used instead of the using sexual intercourse with young girls. The herbs can also chase away evil spirits that may keep on disturbing those remaining in the family of the deceased (Female Traditional Counsellor, Non-intervention area 3).

Overall, although there were rituals that could increase the risks of ASRH problems, changes in the social norms together with having alternatives to the way of carrying out the current rituals could reduce the risks associated with the rituals.

5.4.3 *Marriage and Childbearing as Social Status*

Early marriages and early childbearing were common in Mangochi District. The study found that about 13% of women in Mangochi got married before the age of 15 years while majority (about 70%) enter into marriage between 15-19 years (Figure 5.5).

Figure 5.5: *Age at First Marriage among Women in Mangochi District*



Source: CRH (2004)

This finding concurred with findings in other parts of Malawi that showed that most girls got married by their eighteenth birthday and girls entered marriage earlier than boys (MoEST 2002).

Marriage and childbearing practices in Mangochi had a bearing on social status of people. It was learnt that once girls became pregnant, for instance, they were regarded as adults and the society's views of them changed. Besides the girls' or boys' status, the girls or boys' parents' social status changed by virtue of becoming grandparents which was valued in the society. Most parents were also proud when their daughters had become pregnant or their sons had impregnated girls because the pregnancies initiated a celebration called ''*litiwo*[14]' which was an essential component in the sexual development of young people especially girls. On the importance of *litiwo*, in the Malawian societies, Maliwa (1978:118 - 119) also reveal

> In the olden days (especially among Yao, the Chewa [the Nyanja] and the Lomwe), this ceremony (known as "litiwo" in Yao or "Chisamba" in Nyanja) was so important and valued that if a mother did not send her daughter there, she was punished.

Moreover, the study also found that some girls felt that having a child raised their social status because they were allowed to participate in women's social activities

> Some girls want to bear children so that they can start participating in some community activities which they couldn't if they had no babies like '*litiwo*[15]'. […] This is a function attended by women who have babies and is valued in the society (Female Adolescent, 16 years, Intervention Area 3).

The study also noted that most girls associated childbearing with increased respect in the society and autonomy in sexual life. For instance, some girls cited that when one had a child, she was not restricted in her sexual life. Others also mentioned that unlike girls without children, those who had given birth had access to many loan schemes from loan lending organisations like Pride Africa and Finca Malawi. Such practices resulted in more girls to perceive childbearing as important. As a result of these factors, most young

[14] Litiwo is a traditional celebration among the Yao and Chewa tribes where a woman who is having her first pregnancy or has just given birth to the first baby is given advice on motherhood and caring for their family.
[15] *Litiwo* is the traditional ceremony held when one is pregnant or has a baby to mark her transition into female elite group in the society.

women and the communities in which they lived made little effort towards the promotion of practices that could protect girls from becoming pregnant.

Moreover, it was noted that early marriage practices that could increase the girls' vulnerability to SRH problems was common in some Malawian societies. The increased prevalence of forced and early marriages was also reported in local media in Malawi (Nkolokosa 2005). Although most people acknowledged the complications associated with early child bearing due to early marriages, most communities did not act to curb such threat. Instead, forced marriages were acceptable in the society as reflected by people's passivity to prevent them as Nkolokosa (2005) narrated

> The man who married the girl also has relatives and neighbours. Where were they when the girl came to play the wife in the house? It is difficult to assume that this marriage was known by the three only — the grandmother, the man and the girl. Others, however few, should have known the plan to marry the girl. Some might have seen the girl taken to the man. She might have confided into peers. Why was there all this silence until the time the girl ran to the district assembly? […] "A culture of silence is very dangerous. We need whistleblowers."

Although forced marriages were common, this only happened to girls. Male adolescents were not forced to marry; instead they were encouraged to continue with their education. This practice also hindered the girls from development that could increase their autonomy in their SRH.

Notably also, though human beings are supposed to have rights to decide when to marry (United Nations 1995a), the Malawi Constitution (Malawi Government 2004) gave the authority for parents to consent to marriages of their daughters as young as 13-15 years. This together with other factors mentioned above might have contributed to the increased incidence of early marriages which could eventually risk adolescents to SRH problems.

5.4.4 *Father-Daughter Incest: 'Chicken Drinks Its Own Eggs?'*

Although premarital sex was prohibited and parents and relatives acted as protectors of their daughters against such behaviours, incest was another social practice that was common in some societies in Mangochi. Incest is defined as sexual intercourse between closely related persons through biological or family ties (Fisher 2003). It includes relationships that may be related by birth or by those who live in the same household or

even related by adoption, marriage or clan (ibid.). In Malawi, father-daughter incest was more prevalent. Evidence elsewhere also showed that there were some cases where women had sex with their young male relatives (MHRC 2007).

Such practices deny the victims their rights to SRH. The victims are powerless and hence cannot negotiate safer sex.

Several reasons were attributed to such practices. Some fathers who were perpetrators of such behaviours argued that there was no case against them as they were having sex with their own daughters. One of the fathers narrated "*Why do people follow me? Don't they know that 'chicken drinks its own eggs?' Who accuses it?* (Father abuser, Intervention Area 3).

Moreover, some men also thought that because they provided for the livelihood of their daughters, they had all the rights to do whatever they wanted with them

> When I asked him, he said he is one looking after her daughter- he buys food, clothes, school uniforms and everything. So why are people bothered about his actions on his daughter- she is not somebody's daughter (White Ribbon Alliance staff, Intervention Area 3).

While incest is illegal in Malawi (Malawi Government 2004), it appeared to be socially acceptable in the Mangochi community. It was noted that such cases were not reported by the communities to law enforcers though community members knew it was illegal. Others however argued that such cases were unreported because they were discontented with the punishment given as the perpetrators got away with a minimum punishment or no punishment at all, as evidenced in a court case which acquitted the woman accused of raping a young boy in another part of Malawi (Nation Newspaper 2007). The court judgement was informed by the social belief that sex cannot be initiated by females.

In some cases where such incest cases were public, the cases were privately resolved by traditional counsellors or village headmen for fear of damaging the men's reputations. Where the perpetrators pleaded guilty, they were usually asked to apologise to their wives and the village headmen or paid a small charge equivalent to the price a goat to the village headmen for damaging the reputation of their villages.

Moreover, young women and men did not report sexual violence or rape for fear of stigma or physical assault by the perpetrators because the victims were not protected. Also, because of fear of stigma, victims of incest do not disclose such practices to their parents or relatives. Some withdraw themselves from their regular activities such as community participation or interactions in fear that they could be discovered. Others however do not disclose the incident(s) due to the benefits the girls receive from their abusing fathers. This means disclosure could deprive them of the social support they could have from their fathers. Furthermore, due to mothers' disapproval of this behaviour by their daughters, some mothers disowned their own daughters and hence do not offer any advice to them. This also make abused girls fear to disclose to their parents or guardians.

While community responses to such issues could be of paramount importance in the eradication of the practice, evidence showed that the prevailing practices could perpetuate ASRH problems. For instance, most mothers of the victimised daughters did not disclose such issues to other people for fear of divorce, stigma or being harassed by their husbands. In some instances, the study noted, the traditional leaders tend to oppress the publicity of such issues as they feared the damage to the identity of their villages

> Men who were involved in incest cases were kept a secret. Traditional leaders were scared that their social identities as leaders would be damaged if the public knew that people in their areas were involved in such bad behaviours (White Ribbon Alliance staff, Intervention Area 3).

In this way, the way the society resolve the incest cases could potentially perpetuate the practice. Besides incest could also lead to discrimination which may affect ASRH. Therefore, social change to managing incest cases in the communities could potentially be helpful in ASRH promotion.

5.4.5 *Transactional Sex and the Fishing Industry*

Transactional sex was common in Mangochi District particularly because it is a lakeside tourist area. While reports on transactional sex in the district suggested that young women were motivated by financial or material gains for basic survival and subsistence needs when engaging in such relationships, economic growth appeared to have changed the social identities associated with transactional sex. While the sale of fish in the district had

been based on demand and supply, the study found that some businesswomen used sex as bait to entice the young fishermen to sell their fish at cheaper prices. Thus, the businesswomen used sexuality as a means to gain and negotiate economic status. In so doing, business women boosted their business identities by having higher economic gains.

Additionally, the study also found that some women also used sex as bait in other situations. For instance, it was learnt that some young women who wanted to get employment in the hotels along the lake used sex to induce their potential managers to give them the job. Thus, sex was used to improve the girls' employability credentials as compared to other boys who might have similar qualifications to the girls. In this case, power associated with sex locally described as '*bottom-power*' increased young women's social identities for employment. In other words, sex enhanced women's social identities in the business and industry employment opportunities. However, as protective measures were rarely used during the intercourse the practice could increase adolescents' vulnerability to SRH problems.

Apart from the business identities, the business transaction processes also raised the social status of the young men. The boys for instance acquired the high status due to their association with the so-called 'high status women' from the cities. Because of this, such boys attracted several local women and girls not for financial or material gains only but also because of their new status as another male adolescent narrated '*Panopa azimayi ndi atsikana amandifuna chifukwa amadziwa kuti ndimagona ndi azimayi a mtauni*' (*Now women and girls want to have sex with me because they know I have sexual relationships with women from the cities* (Young Fisherman, 17 years, Intervention Area 1). Moreover, young fishermen who had sexual relations with businesswomen could also propose sexual relationships with local women without fear because of their acquired social status. Thus, the associated status raised the young men's social status and self-confidence among their peers and others in the community.

> If one is able to have intercourse with someone from the city, what can fail him to have sex with other girls or women from our area? In fact, once they know that one of your girl-friend is from the town, they all come to you trying to induce you to have sex with them. […] They do not come for money but they perceive you to have high status which can also raise their status among their female peers (Young Fisherman 17 years, Intervention Area 1).

On another account, transactional sex in business was perceived by young men as an opportunity to show their masculinity. While women did have more sexual powers, the boys perceived that their involvement in sexual intercourse with such women was an imposition of hegemonic masculinity over the women. Several instances were cited where boys interviewed were proud of how 'real men' they were by having intercourse with such women with whom in normal circumstances they would have no chance at all. Phrases like "*ife ndi amunamuna ogona ndi azimayi a m'tauni*" (We are real men who have sex with women from the city) (Young Fisherman, 17 years, Intervention Area 1) were common among those who had sexual relationships with businesswomen. Because of this perception, most boys tended to feel that they were in control and were on the winning side despite their losses in financial terms. This attitude increased the boys' adoption of unsafe sex practices that could increase their risk of STIs and HIV/AIDS because use of any protective measures like condoms was perceived to compromise their sexual enjoyment

> In order to enjoy sex with such high class women from the cities, you need to go 'bare'- no condoms. Body-to-body contact means you have the natural sex (Young Fisherman, 18 years, Intervention Area 1).

Thus, the capital economy has altered the motive of transactional sex whereby it was being used to boost economic gains by women. The use of sex to boost economic gains could however increase adolescents' vulnerability to SRH problems.

5.4.6 *Education and Religion*

Other social factors like educational status and religion appeared to play a role in adolescent sexual behaviours in Mangochi. It was for instance observed that more adolescents who were in school adopted safe sex practices particularly abstinence, condom use and having one partner in both intervention and non-intervention areas (Table 5.6).

Table 5.6*: *Current Studentship and Adoption of SRH Behaviours

Demographic Variables	Condom Use in past 6 months (%)		Secondary Abstinence (past 6 months) (%)		Current Contraceptive Use (%)		Having One Sexual Partner (%)		Primary Abstinence (%)	
	INT	NON	INT	NON	INT	NON	INT	NON	INT	NON
Currently schooling						**			*	*
Yes	63.2	54.2	65.5	67.4	10.6	2.2	37.0	34.1	69.6	74.6
No	36.8	45.8	64.1	64.3	15.4	12.9	32.0	26.9	40.5	40.7

*p=0.000, **(p=0.011)

Further analyses indicated that significantly more adolescents who were schooling adopted primary abstinence in both intervention (X^2=34.989, df=1, p=0.000) and non-intervention (X^2= 45.466, df=1, p=0.000) areas.

However, while a higher proportion of adolescents who were currently attending school used condoms in the past six months in the intervention areas, fewer did so in the non-intervention areas (Table 5.6). This could however be attributed to the increased availability of and access to condoms in Edzi Toto Clubs[16] in schools in the intervention areas which was not the case in the non-intervention areas.

Moreover, unlike adolescent scholars, more adolescents who were not attending school were significantly using contraceptives (Fisher's Exact test X^2= 7.134, df=1, p=0.011) in the non-intervention areas. Several explanations were evident from the qualitative data. Firstly, more adolescents who were schooling were young and hence they thought they could not become pregnant. Secondly, as students were not socially expected to be sexually active, it was more difficult for them to access SRH services unlike their non-schooling counterparts.

> Pupils have problems to access services at the clinic. Providers do not expect them to have sex and hence they are harsh when they ask for contraceptives at the clinics. [...] When a girl is out of school, everyone expects her to be free to have sex as she can get married any time. As a result, nurses help them easily (Health Worker, Intervention facility 3).

The social expectation that non-scholars were expected to be sexually active was also reflected in the survey results that showed that fewer non-scholars practised primary abstinence and most of them had more than one sexual partner (Table 5.6). Being out-of-

[16] Edzi Toto Clubs are clubs composed of students fighting against HIV/AIDS

school was associated with readiness to marry or commence childbearing and this affected adolescent' sexual behaviours in most societies.

However, as adolescents in schools were not socially expected to be sexually active, some of them adopted safe sex practices in order not to become pregnant or contract STI or HIV as that would show that they were involved in sexual activity. In other words, adoption of safe sex practices was influenced by their desire to maintain their social reputation, as another girl narrated

> My parents do not expect me to have sex before I enter into marriage. This time is for me to do my studies until I finish so that I can get a good job in the future. If I become sexually active, people will think that I am a prostitute and my parents can shout at me for disobedience (Female Adolescent, 15 years, Non-intervention Area 4).

While schooling was important in ASRH promotion in one way or another (Table 5.6), analysis of the data revealed that education exposed adolescents to SRH information which was at odds with the traditional expected way of behaviour. For instance, adolescents in schools were provided with pamphlets that promoted condom use and this could empower them to be aware of the benefits of condoms. Schooling also took adolescents away from their homes and this delayed their marriages. It also empowered adolescents through provision of SRH information which was not traditionally accessible to them. All these actions which were traditionally inaccessible to adolescents helped adolescents to have choices of sexual behaviours and this might explain in the adoption of safe sex practices. However, it was noted that education could create an ambiguous culture due to its promotion of western ideologies in ASRH. This could also result in conflict between the traditional and western norms regarding sexuality.

Although current schooling status was associated with adoption of safe sex practices, the qualitative results showed that education level was not proportionally associated with use of safe sex practices. The results showed that some adolescents who had high education status, especially Catholic Christians and other religious adolescents objected to contraceptive use.

While schooling had potential for improving ASRH, there were some challenges or obstacles that could affect ASRH. For instance, it was noted that policies that prohibited

students from getting pregnant only expelled pregnant girls from schools while their male partners continued with education. This could encourage the boys to continue in unsafe sex practices that could put girls' sexual health at risk. Thus, this policy did not promote gender equality.

Besides, teachers were not well prepared to facilitate empowerment of young people to control their sexual health. For instance, while empowerment for ASRH could empower them to have different options to promote their sexual health, most teachers only promoted abstinence as the strategy for ASRH promotion. Most teachers however discouraged condom use as it was against their culture

> I teach my students about HIV/AIDS, STI and pregnancy prevention. I teach them about the importance of abstinence and of obeying to parents' advice […] *(Interviewer posed question on teaching about condoms).* Mm … I don't actually encourage them to use condoms as it is socially not expected that they should use them. I just mention them as one of the ways that can be used to prevent HIV/AIDS in case a question comes during their examinations (Primary School Teacher, Intervention Area 3).

Moreover, due to stigma associated with premarital sex, teachers who taught Sex and AIDS education were stigmatised by the students and communities because they were perceived to promote premarital sexual activity.

> Teachers who teach sex education are given bad names. People think that by teaching such subjects to young people, they are encouraging them to have premarital sex (Primary School Head-teacher, Intervention Area 3).

Apart from the role of education in ARH, religion greatly influenced adolescent sex practices and was indeed the basis of the recurrent morality concerns by the opponents of adolescent sexuality in Malawi. It regulated sexual behaviour, including attitudes and the use of SRH services.

In Malawi, the majority of citizens acknowledged the reality of God and His active presence in the world. There was a general understanding that whatever happens in personal, political and social life reflects the will of God (see also Monfort Press undated). Even in popular songs one can hear the words "*nobody can change it*" (Monfort Press undated: 4) as if the will of God would follow a stiff and blind mechanism. As a result of

these religious beliefs, most religious communities in Malawi disapproved use of SRH services. While few of them only discouraged condoms, most of them also discouraged other SRH services especially modern contraceptives as it was believed that pregnancy was a gift from God. Moreover, it was believed in the religious circles that condom and contraceptive use could promote promiscuity. As such, use of SRH services for other purposes other than treatment of medical conditions was disapproved of by almost all religions in Malawi.

> Our church does not allow use of family planning services. If one uses them, it means s/he is not a good member. You can only go if you have an STI (Female Adolescent, 19 years, Intervention Area 1).

This observation was also echoed by other religions which were against condom promotion

> Our position as a religious grouping is that condoms are not acceptable to be used by our members. They can encourage sex outside marriage. […] Whatever the case, use of contraceptives and condoms are not acceptable to our unmarried young people (Religious leader 1, Intervention Area 1).

However, it was observed that the chastity stand was pointed out as also posing several dilemmas for the sexually active faithful adolescents who, being humans were aware of the threat caused by some SRH problems like HIV/AIDS but were also required to adhere to 'no SRH service use doctrine' from their religions. This dilemma was best captured in the following statement from one female adolescent

> As a Christian, I am not supposed to use the modern contraceptive methods because they are not allowed in our church. This is against our religious values. [*Interviewer posed a question regarding HIV prevention and religion among sexually active adolescents*]. Mmmh. This is now a problem. Young people are aware of the threat of HIV/AIDS on their lives. Most of them would like to use condoms but now they think that what if other church members know (Female Adolescent, 17 years, Intervention Area 3).

Because of the religions' stand against SRH, most of their actions did not empower young people to promote their SRH. They did not teach adolescents about sexuality and SRH. They never encouraged young people to use SRH services especially that a good proportion of health facilities were owned by the religious institutions. This was so, though many religious leaders were aware of their unmarried young members' involvement in sex and the fatality of some SRH problems like HIV/AIDS. Several

examples from the in-depth interviews given by church leaders also showed that most female adolescents who were expelled from schools due to pregnancies were reported to be strong members of their religions.

While most of the religious leaders emphasised abstinence only for the unmarried, the study revealed that some of the religious leaders were the perpetrators of sexual abuse among the young people. This was also reflected in the mass media which showed that a sheikh in the study area was convicted because of defiling a girl aged five years (see Annex 19). All this could affect ASRH promotion.

5.5 ***Conclusion***

Overall, the evidence above reveals that social and cultural factors such as ambiguous normative culture, stigma and structural gender asymmetry had a stronger influence on the adoption of safe sex practices among unmarried adolescents. As such, health promotion interventions need to address the ambiguous cultural context influencing sex practices if they are to be effective. Therefore, the following chapter will examine the capacity of the health sector to address such factors in order to promote ASRH among unmarried adolescents.

Chapter Six

Youth Friendly Reproductive Health Services: Strategies, Implementation and Impact

6.0 *Introduction*

Youth-friendly reproductive health services (YFRHS) have been viewed by donor agencies and national governments as a panacea in ASRH promotion policy documents (UNFPA 2003). However, establishing its capacity to promote the adoption of safe sex practices among unmarried adolescents has been complicated by the dearth of studies focusing on such a group. Based on the Ottawa Charter of Health Promotion framework (WHO 1986) as the tool for analysis, this chapter presents findings on the capacity of facility-based YFRHS in the promotion of ASRH in rural Malawi. The Ottawa Charter of Health Promotion stipulates that in order to promote health, health promotion initiatives should be able to meet five key issues: developing personal skills, strengthening community action, creating supportive environments, reorienting health services and building public health policy (ibid.).

In the light of this, this chapter argues that unless YFRHS empowers individuals and communities as well as reorienting the health sector policies and programmes to optimise ASRH promotion, facility-based YFRHS may not impact on SRH among unmarried adolescents. The chapter uses data collected from participant observations, in-depth interviews, documentary reviews, client exit interviews and survey.

Using the above theoretical framework, this chapter is divided into three sections examining the capacity of the YFRHS to address ASRH. The first section examines the social and policy environment for ASRH promotion in Malawi. The second presents how YFRHS are implemented in Malawi. The third section examines the impact of YFRHS on the adoption of safe sex practices by unmarried adolescents. The chapter concludes that the way the YFRHS was implemented in Malawi was not effective in promoting ASRH among unmarried adolescents as it had no capacity to address the social norms which were the main determinants of sexual behaviours.

6.1 ***Promotion of Enabling and Supportive Social and Policy Environment***

6.1.1 *ARSH Policies and SRH Rights*

Malawi was party to the 1994 ICPD consensus that reaffirmed the priority of providing SRH services for youth (United Nations 1999 in Mahy and Gupta, 2002). In line with the ICPD Plan, Malawi formulated and endorsed the National Youth Policy (NYP), the National Population Policy (NPC), National Gender Policy (NGP), Reproductive Health Policy (RHP) and Family Planning Policy and Contraceptive Guidelines (FPPCG) with the aim of empowering young people to promote their SRH. The policies contained several components that could facilitate the empowerment of adolescents, communities and health workers for ARH (Table 6.1).

Table 6.1: *SRH Related Policies: Policy Attributes related to ASRH*

Policy Contents related to ASRH Promotion	**National Youth Policy**	**National Population Policy**	**FP and Contraceptive Guidelines**	**RH Policy**	**National AIDS Policy**	**National Gender Policy**
Targeted Adolescents	√	×	×	√	√	√
Sexuality Education	√	√	×	×	×	√
SRH Education	√	×	√	√	√	√
Gender Awareness	√	√	×	√	√	√
SRH Rights	√	√	√	√	√	√
Life Skills training	√	√	√	√	√	√
Functional Education	√	√	×	×	√	√
Access to SRH services	√	√	√	√	√	√
User participation	√	×	√	√	√	√
Community Involvement	√	×	√	×	√	√
Social Mobilization	√	√	√	√	√	√
SRH Network and coalition	√	√	√	√	√	√
Sexual Exploitation	√	×	×	×	√	√
Economic Opportunities	√	√	×	×	√	√

√= Yes, ×=No

Thus, the SRH policies in Malawi have potential to empower adolescents and communities through promotion of SRH education, social/community mobilisation and improved access to SRH services. This is also complemented by the training of health workers as YFRHS providers (NYCOM 2001). However, a critical analysis of these policies and qualitative results from the interviews reveals that the approaches used in the policies to empower adolescents, health workers and communities for ASRH promotion could not transform the social norms that disempower these people in their ASRH promotion initiatives.

> We have policies for the provision of SRH services. We have the National Youth Policy and many others. But none of them focuses on changing the culture which influences young people's sex practices (YFRHS Trainer, Intervention Area 1).

Moreover, although the 1994 ICPD promoted SRH rights (United Nations 1994), it was noted that some SRH services like some contraceptive methods (emergency contraception, Norplant, IUCD, surgical sterilisation, abortion services) were not accessible to young people even if they chose to use them. Thus, the adolescents had no SRH rights in comparison to the rights adults had.

> The way I see it, the policy mainly assists married people because there are situations where teenagers come to have their unplanned pregnancy terminated but the policies do not allow that even if they want to do that with good intentions to continue with their education (Clinic Manager 1, Intervention Facility 2).

Furthermore, some of the SRH rights conflict with the social and cultural norms. For instance, contrary to the SRH rights, the norms of the societies view males as controllers of sexual issues. Also, while the SRH rights stipulate that each person has the rights to access SRH services (MoH 2002); most parents felt that it was unacceptable for the health workers to give SRH commodities like contraceptives including condoms without their approval.

Other evidence from the qualitative results suggests that culture influenced the policies as culture stipulated what is socially right and wrong: "*Our culture considers abortion as killing a baby and our policy does not allow abortion, so is emergency contraception, except as a part of therapeutic treatment* (Clinic Manager 1, Intervention Facility 1). Moreover, because girls are expected by the society to bear children, some services like permanent sterilisation are not acceptable for young people regardless of their choice not to have children in their life.

The study also noted that although the policies promote abstinence, have one faithful partner and condom use (ABC) in the promotion of SRH among unmarried adolescents (NAC 2003), most programmes targeting unmarried adolescents promoted abstinence only. For instance, some local community-based institutions like Youth Against AIDS Organisation (YAGAO) funded by NAC's Global Funds only promoted abstinence as the

only way for SRH promotion for unmarried adolescents. However, due to the promotion of community-generated solutions to ASRH promotion, NAC did not object although an abstinence-only strategy could not meet the SRH needs of some of the sexually active adolescents who might not manage to refrain from sex

> Our health policy emphasises on ABC, but in actual fact, everybody including health workers promotes abstinence among unmarried people. […] There are also government-funded organisations which promote abstinence only and talk against condom use in the district (YCBDA 2, Intervention Area 2).

Other evidence also reveal that most political, religious and opinion leaders do not support safe sex practices other than abstinence due to social norms that prohibit premarital sex as reflected in one of the billboards (Figure 6.1).

Figure 6.1: *Billboard Displaying SRH Promotion Message in one of the Cities*

Additionally, while there were a number of NGOs that provide SRH services, most were guided by tailor-made policies in their work. Some of their policies however did not promote some components of SRH promotion. The Catholic Church affiliated health facilities for instance never promote modern contraceptives including condoms. While some religious-affiliated health facilities have policies which allow provision of SRH services, it was noted that some of their service providers appeared to be uncomfortable to

provide such services to unmarried adolescents due to the institutional values and beliefs, some of which are undocumented, which contradicted with the national ASRH policies

> This hospital promotes Christianity principles which prohibit premarital sex. Therefore, it provides contraceptives and condoms to married people and advises adolescents to abstain from sex until marriage as Christianity doctrines do not allow premarital sex. (*Interviewer question: what if unmarried adolescent asks for condoms*). Mmh. (speaking reluctantly) Some staff provide such items to unmarried adolescents while also emphasizing on abstinence (Provider 2, Intervention Facility 3).

These evidence means that the social norms related to premarital sexuality influence the contents and implementation of policies in ways that could hinder ASRH promotion.

6.1.2 *Adolescent Sex Practices and Laws in Malawi*

Although there are currently no specific laws around adolescent reproductive health, some of existing laws in the Malawi Constitution and legal system could promote ASRH. However, there is no enforcement. For instance, the prohibition of sexual acts between a woman or man with a person under the age of thirteen years with or without consent as well as the Malawi Constitution stipulation that people shall be protected from forced marriages (Malawi Government 2004 - Section[17] 22.4), it was found that forced marriages were common in the district as also narrated by one 19-year old female adolescent who was forced to get married

> Some of my family members encouraged me to find a boyfriend and then get married. They even went to my parents, telling them that the only thing left for me was to look for a partner (UN IRIN 2004:1).

The Malawi Constitution's provision that girls could enter into marriage as young as fifteen years (Malawi Government 2004 - Sections 22:6-7) as well as the constitutions' stipulation that allows parents to consent to their daughters entering into marriage at the age of thirteen years could also compromise ASRH promotion as early marriages can lead to early motherhood. Moreover, though the Constitution[18] stipulates that the State shall discourage marriage of those under fifteen (ibid. - Section 22:8), there was no reinforcement as marriages were traditionally organised and hence there was no tracking

[17] Section means parts of the Malawi Government Constitution 2004
[18] Constitution means Republic of Malawi Constitution

of people's ages at marriage. As such, the culture controls marriages and parents have overall say on their children's marriages

> *Interviewer*: The government has put the acceptable age a girls can enter into marriage. Do people follow that in this community?
> *Respondent*: No, we have traditional marriages. Traditionally, parents or uncles have the control of when to allow their daughters or nieces to enter into marriage. It has nothing to do with the State (Traditional Leader 2, Intervention Area 2).

The government stipulation and lack of reinforcement as well as the traditions which allow early marriages could violate young people's rights to education which might lead to long-term disempowerment in SRH promotion. This could result in economic disempowerment among young women due to unemployment as a result of low educational levels. Because of this, some girls could opt for the sex trade while other may be subservient to their male partners in everything including sexual matters in order to earn their living.

Additionally, although the Constitution (Malawi Government 2004a - Section 22:2) stipulates that all family members would be protected from exploitation including sexual abuse, father-daughter incest was common (see Chapter 5) and most of the culprits of such practices were not punished. Lack of punishment could perpetuate the practice in the society. The study also found that the laws related to rape were engendered. Several cases were reported where women were acquitted after raping boys as the "*Malawi legal code does not have the provision for a woman raping a boy*" (Paralegal staff, Intervention Area 1). In this case, there was no legal protection against boys' rape and this could worsen ASRH as some women who could rape these boys might transmit SRH infections. Overall, the ambiguities in the laws and lack of enforcement in Malawi could aggravate social practices that could increase ASRH problems.

6.1.3 *Multisectoral Collaborations: Strengthening Community Action*

Considering the diverse nature of the determinants of ASRH, working in partnerships with other people was one of the crucial components of ASRH promotion in Mangochi. The partners included local traditional and religious leaders, local communities, governmental sectors, NGOs and community-based organisations (CBOs). These partners were involved

in many ASRH activities including YFRHS programme management, planning, implementation and monitoring of ASRH activities (see Figure 6.2).

Figure 6.2: *Traditional and Religious Leaders Holding Group Discussion at YFRHS Management Meeting*

This collaboration provided a forum where topical issues including social and cultural norms affecting ASRH were discussed. The partners also expanded the scope of ASRH service provision. The religious institutions for example conducted peer education training that imparted knowledge of HIV/AIDS, gender roles and relationships to the adults and youths of their denominations. They were also involved in community mobilization focusing on changing social and cultural practices that encouraged adolescents to adopt unsafe sex practices.

> Traditional leaders are the gatekeepers of the culture which define sexual morality. Their involvement helps the programme to facilitate changes in some traditional practices that can increase vulnerability of young people to SRH problems (NnN Project staff, Mangochi).

The involvement of the traditional leaders bore some positive impact on ASRH promotion. Some changes in traditional initiation practices occurred after discussions that included reflection on the consequences of the existing practices and alternatives to the practices.

> We discuss how we can do initiation rites safely without the risk of HIV transmission or early pregnancies. […] We also encourage use of songs with appropriate messages on SRH as opposed to those that promoted unsafe sexual behaviours among young people (Initiation Counselor 2, Intervention Area 4).

Similar observations were also reported in other non-intervention areas where people had discussed their concerns about HIV/AIDS and traditional circumcision

> After discussing with our traditional leaders about the dangers of traditional circumcision, we changed the way we do it. We now encourage parents to send their boys to hospitals for circumcision. We assemble them together after their return from the hospital. We also discourage giving them messages that can encourage unsafe sex practices as we used to do before (Initiation Counselor 1, Non-intervention Area 3).

Similarly, respondents in some areas reported that people were using traditional herbs instead of sexual intercourse with young girls as a means for cultural cleansing.

Although working in partnership could create an enabling and supportive environment for ASRH promotion, collaborative working was not unproblematic. Different partners had different values on promotion of ASRH among unmarried adolescents. For instance, while the YFRH programme was promoting all preventive measures ABC approach, traditional and religious groups disapproved of condom use as an appropriate preventive measure for unmarried people

> Unmarried adolescents are not supposed to have sex. To have sex with who? If they want sex, they must marry. […] Even if they are having sex, the church cannot promote condom use as that is encouraging premarital sex (Religious leader 2, Non-intervention Areas 1).

Furthermore, some religions considered SRH problems particularly HIV/AIDS as a direct consequence of God's interference with the sinful world.

> AIDS is punishment for sin. Those who get it duly deserve it for their sin and their death cannot be avoided. If society turns away from God, that's the consequence (Religious leader 2, Non-intervention Area 1).

Additionally, while the YFRHS programme discouraged some cultural practices like initiation rites that promoted unsafe sex practices, most traditional leaders were against such change

> Initiation rites are our tradition. It is our identity among other societies. We learnt it from our ancestors; we can't change that culture over night (Traditional leader 3, Intervention Area 4).

Because of these social attitudes, people adhered to norms that predisposed the adolescents in the study areas to SRH problems.

> We've been receiving materials for safe circumcision like razor blades but I have never seen them being used during initiation. Initiators still use their knives for circumcision as people believe that their instruments have herbal medicine that promotes healing of circumcision wounds (Peer Educator 3, Intervention Area 3).

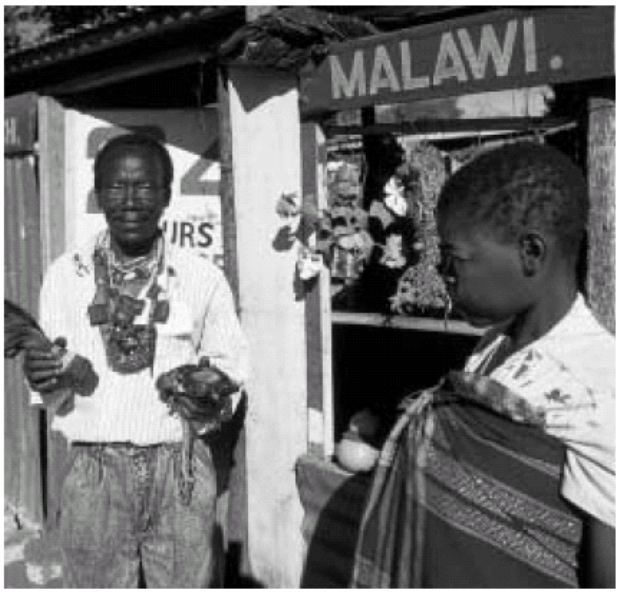
Although the health sector saw the involvement of education sector as an opportunity to reach many adolescents who were in schools, the education sector has policies that only allow SRH education but not provision of services like condoms despite that increased cases of pregnancies among schoolgirls reported in all schools. Among others, the philosophy of the education sector aimed to maintain the culture which traditionally did not allow premarital sex

> Our schools want to conserve our culture. If we tell them something different from our culture, then they will go astray. We don't want our culture to die. That is why our ministry is called ministry of education and culture. We aim to bring up the youth with good behaviour which is consistent with Malawian culture (Primary School Head teacher 1, Intervention Area 3).

Similarly, religious communities were against promotion of condom use despite their acknowledgement that there was HIV/AIDS and many of the members were at risk or had HIV. Instead, they argued that people needed to follow God's commandments to avoid HIV/AIDS. Other leaders were also against the introduction of AIDS education in schools as they thought that could promote premarital sex. Apart from that, they were against any promotion of sexual activity regardless of its form, even if it was safe sex.

While the YFRHS programme intensified its partnership with the community leaders, some key players like traditional healers were left out. This was so despite that majority of Malawians including young people rely on traditional healers for many of their health care needs (NAC 2003) - See Figure 6.3.

Figure 6.3: *A Pregnant Girl Seeking Health Care at a Traditional Healer*



Moreover, the government of Malawi recognises the existence of traditional health care system (Malawi News Reporter 2005).

Despite the community's trust in the traditional healthcare providers, most health professionals question the effectiveness of the traditional medicine. Among others, the beliefs of traditional health care system conflict with those of modern health care. For instance, while HIV/AIDS is considered as any other infections in modern science, traditional healthcare considers HIV infection or AIDS as conditions which are caused by witchcraft and hence can be cured using traditional medicine as one herbalist explained

> When conditions like HIV/AIDS can't be cured at the hospital, the patients come here and I cure them. Most of such conditions are due to witchcraft (Traditional healer, Intervention Area 1).

Because of such differences between the modern and traditional models of health and illness, it was difficult for the health professionals to accept the traditional healthcare providers into the partnership as they thought the health workers would be forced to incorporate the traditional healthcare beliefs into the YFRHS package. Although the health workers' disapprove traditional health care, interviews with community members revealed that some community members including adolescents trusted the traditional

health care as their primary source of SRH care because they believed that most of SRH problems were a result of witchcraft or disobedience to traditional norms.

> There are some conditions which doctors at the hospitals cannot treat. They are failing to treat AIDS, but some herbalists are able to treat it. […] The community cannot survive without these traditional healers. They know our culture and understand our health problems (Female Adult, Intervention Area 3).

Because of these attitudes, the exclusion of traditional healthcare providers in the partnership reduced access to modern SRH services by unmarried adolescents

> Many boys seek for traditional medicine before they go to the hospital for STI treatment. Girls visit traditional birth attendants whenever they miss menstrual cycle. If they can be given contraceptives or condoms, these adolescents can easily access them (Youth Zone Coordinator 3, Intervention Area 3)

Thus, while partnership could facilitate ASRH promotion through increased outlets of SRH and sexuality counseling services, some cultural norms could be a barrier to the creation of a conducive environment for ASRH. Moreover, the tension between cultural and western ideologies of health could affect ARH promotion.

6.2 ***Reorientation of ASRH Services: Youth-Friendly Services and Empowerment***

Following the introduction of YFRHS in Mangochi, the provision of ASRH services was reoriented to address and meet the SRH needs of adolescents. The reorientation saw increased community involvement in ASRH (see section 6.1.3), adolescent participation and provision of SRH to adolescents in a friendly manner.

6.2.1 *Promoting Adolescent Participation in YFRHS Provision*

Adolescent participation was one of the key components of YFRHS in Mangochi. Adolescents were involved from the inception of the programme, planning, implementation, monitoring and evaluation of YFRHS activities. Besides, they were also involved as service provision at both health facility and community levels. The programme trained over 100 YCBDAs, 20 VCT youth counselors and 200 peer educators who were actively involved in the provision of SRH services to young people in the community (Figure 6.4).

Figure 6.4A**:** *YCBDA Counseling a Female Adolescent in the Community*

Besides the community involvement, adolescents were also involved in the provision of SRH services at the health facility (Figure 6.4B).

Figure 6.4B**:** *Adolescent Female VCT Counselor at Work at VCT Centre*

Apart from the community health volunteers, the orientation also saw establishment of community resource facilities for adolescents (Figure 6.5).

Figure 6.5: *Community Youth Resource Centre*

There are over 400 youth clubs and 39 youth resource centres in Mangochi. Evidence from the survey shows that the community youth health volunteers (CYHVs) played a significant role in ASRH promotion. The results showed that more adolescents who met the community youth health volunteers adopted safe sex practices (Table 6.2).

Table 6. 2*: *Percentages of Adolescents who Adopted Safe Sex Behaviours versus Meeting CYHVs

	Primary Abstinence		Secondary abstinence (past 6 months)		Have one sexual partner only		Condom Use (past 6 months)		Currently using Contraceptives	
	INT	NON	INT	NON	INT	NON	INT	NON	INT	NON
Meeting YCBDA										
Yes	*		s						***	
No	67.1	56.7	70.9	69.2	39.6	34.6	73.7	25.0	28.9	11.5
	45.7	53.3	50.0	62.5	24.3	19.0	58.5	48.0	8.5	4.7
Meeting Peer Educator	n			y					w	
Yes	64.0	65.8	65.5	70.0	41.2	40.0	71.4	44.4	33.3	10.0
No	41.9	61.5	61.1	45.0	34.7	31.0	57.4	33.3	10.2	6.0

*p<0.001, ***p<0.002, n (p<0.014), s (p<0.015), w (p<0.013), y (p<0.025)

Note

Those who met peer educators; n=177 (intervention area) and n=150 (non-intervention area)

Those who met YCBDAs; n=129 (intervention area) and n=64 (non-intervention area)

Except for primary abstinence, all calculations were based on number of adolescents who were sexually active.

Further analysis showed that significantly more adolescents who were sexually active and met YCBDA were using contraceptives in the intervention areas (Fisher's exact test

X^2=11.16, df=1, p<0.002), while those who never had sex continued to abstain from sex in the intervention areas (X^2= 12.00, df=1, p<0.001). Moreover, the statistics show that significantly more sexually active adolescents who met YCBDAs abstained in the previous six months in the intervention areas (X^2= 5.88, df=1, p<0.015).

The results also showed that significantly more adolescents who never had sex and met peer educators continued to abstain from sex in the intervention areas (X^2= 6.09, df=1, p<0.014), while more adolescents who were sexually active and met peer educators were using contraceptives in the intervention areas (X^2= 8.12, df=1, p<0.013). However, the study found that significantly more adolescents who were sexually active and met peer educators abstained in the past six months in the non-intervention areas (X^2=4.99, df=1, p<0.025). Notably however from Table 6.2 was that regardless of the area of residence, meeting a CYHV was associated increased likelihood of adopting safe sex behaviours among unmarried adolescents.

While increased access to SRH services distributed by CYHVs might have contributed to the increased adoption of safe sex practices, the qualitative results revealed that the involvement of local adolescents as service providers encouraged the communities to accept and support SRH services for unmarried adolescents. Other adolescents also stated that community and CYHVs' involvement at the community resource centres also allowed adolescents and communities to discuss some of the social issues that hindered SRH use among adolescents.

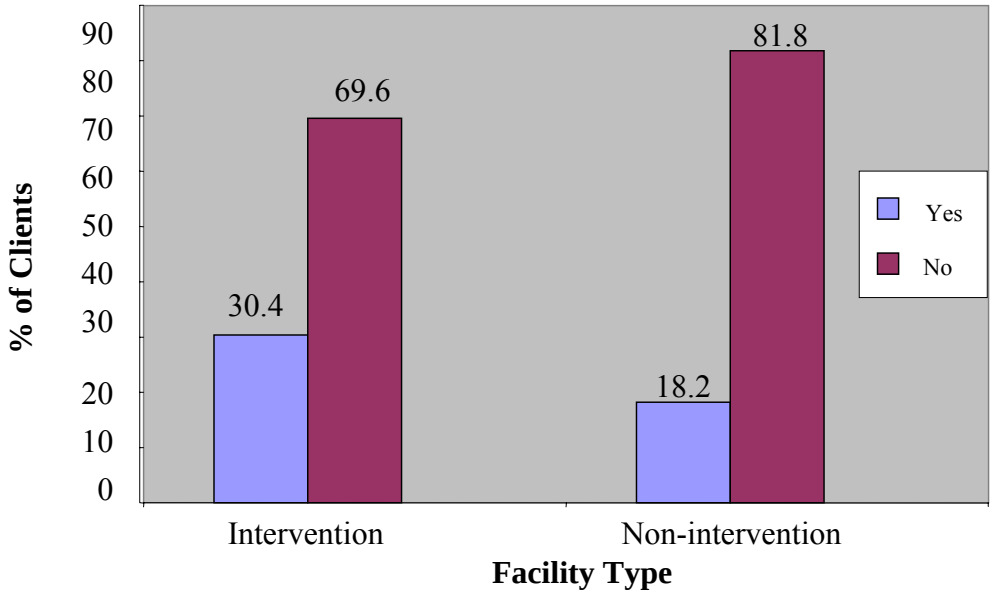
However, CYHVs faced some challenges that hindered their work. It was for instance learnt that the communities stigmatised adolescents who were involved in promotion of ASRH services

> People in the community give you different names if you distribute contraceptives or condoms. They even tell their children that they should not play with CYHVs because they will teach them bad behaviour- premarital sex (Youth VCT Counselor, 18 years, Intervention Facility 1).

Although YFRHS promoted adolescent participation in their care as part of empowerment, most health workers were reluctant to involve them. The survey results showed that only 30.4% and 18.2% of the adolescents clients who had exit interviews at

the intervention (n=21) and non-intervention (n=12) facilities respectively were allowed to participate in the decision-making of their care (Figure 6.6).

Figure 6.6: *Proportion of Adolescents Involved in Decision-Making of Their Care*



Several reasons were attributed to failure of health workers to involve adolescent clients in planning their care. Most health workers thought it was not the adolescents' duty to decide their care as they were not trained to do so as one client exit client narrated

> When I told the nurse the type of contraceptive I wanted, she was furious. She shouted at me that I don't know anything about contraceptive. She knows better and hence she will give me what she thought was better for me (Female Client, 16 years, Intervention Facility 1).

While other health workers said they had insufficient time to allow the participation of their clients because of the large numbers of clients they serve at the health facilities, most adolescent clients were reluctant to participate in their care due to their perceived lack of knowledge on health issues.

> After the nurse taught me different contraceptive methods, she asked me the contraceptive method I wanted. I told her she was an expert to give me what was good for me. [*The interviewer asked why she said so*]. The nurse is trained to advise us on our health care. We go to the hospital to get help from the health workers; otherwise we need not to go if we know what treatment we need. We can just buy from the shops (Female Client, 18 years, Intervention Facility 1).

Such views were also reflected in some health workers who expressed that because they had undergone professional training which was not the case with adolescents, the health workers felt that it was their sole duty to promote ASRH of unmarried adolescents.

> People come to the hospital to be assisted of their problems. If they know how to treat themselves, then why coming to the hospital? We are here to treat their health problems and they are the recipients of our care (Health worker 1, Non-intervention Facility 1)

Moreover, other evidence indicated that some adolescent clients did not participate because of fear of stigma. Some health workers reportedly stigmatised adolescents who seemed to have SRH knowledge.

> If you seem to have SRH knowledge, some health workers ask you- where did you learn that? Others suspect that you have sexual experience and that's why you know. Even if you ask more questions, some providers think you have been doing what you enquire about like if you ask about condoms means you do sex (Male Client, 17 years, Non-intervention Facility 1).

The study further found that other adolescents especially girls did not participate in the decision-making regarding their care or ask questions concerning their problem or care even when asked by the health workers in order to show their humility manifested by quietness which was a quality of a good girl in the Malawian context. All these discouraged most adolescents from active involvement in decision-making regarding their care. However, the study found that while the reorientation of the services aimed to attract adolescents to visit health facilities to access SRH services, it did not attempt to address the cultural factors that influenced the adolescent sexual behaviours.

Overall, while adolescent involvement in ARH promotion was promoted in YFRHS, other social factors associated with sexuality and SRH issues as well as health workers and community's perception about their roles in health promotion hindered adolescents' participation in ASRH.

6.2.2 *Youth Friendly Reproductive Health Services at Clinic*

The introduction of YFRHS saw a change in the approach to ASRH service delivery with the aim to attract adolescents to use SRH services. The reorientation of health services

aimed to create a friendly environment at the health facilities for adolescents. YFRHS reorientation affected service delivery and quality of service providers.

6.2.2.1 *Service Delivery*

ASRH service delivery changed with YFRHS. The reorientation included provision of SRH services in youth only clinics, youth only times, integrated SRH services as well as expansion of the provision of community-based SRH services. Besides, the orientation meant that ASRH service provision was carried out by specially trained staff.

The results from the survey showed that the impact of YFRHS on adoption of safe sex practices was mixed. While visiting clinics was associated with increased condom use, secondary abstinence and contraceptive use in both intervention and non-intervention areas, notably however, visiting clinics was associated with having multiple sexual partners and increase in sexual initiation among those who never had sex in both intervention and non-intervention areas (Table 6.3).

Table 6.3: *Safe Sex Practice Adoption between Adolescents Visiting Intervention and Non- intervention Facilities*

	Condom Use in past 6 months (%)		**Secondary Abstinence (%)**		**Current Contraceptive Use (%)**		**Having One Sexual Partner Only (%)**		**Primary Abstinence (%)**	
Visited Clinic	INT	NON	INT	NON	INT *	NON	INT	NON	INT	NON
Yes	100.0	50.0	75 .0	83.3	50.0	16.7	25.0	16.7	50	60.0
No	56.1	41.8	64.7	66.5	10.7	6.1	35.8	32.7	63.1	65.5

*p=0.009

Further analysis showed that significantly more adolescents who visited SRH clinics were using contraceptive methods compared to those who never visited the clinics in the intervention areas (Fisher's Exact test X^2= 7.189, df=1, p=0.009). Both male and female adolescents interviewed however indicated that this was attributed to the availability of community health volunteers to whom the facilities' health workers referred them to collect SRH commodities (contraceptives, condoms) during their visits

> The nurse gave me the names of some youth who were providing the contraceptives in our communities. These health volunteers have been teaching me about SRH issues. They also encouraged me to continue using SRH services (Female Adolescent, 15 years, Intervention Area 4).

However, visiting clinics was associated with increased proportion of adolescents having multiple sexual partners and initiation of sex among those who never had sex because of the attitudes people had associated with use of preventive means. For instance, many people in the society believed that using preventive measures like condoms meant that one was free to engage in sexual activity. In this way, access to preventive measures meant that adolescents could have multiple partners or have sexual debut as they could not become pregnant or contract STIs or HIV.

> Condoms and contraceptives encourage young people to become sexually active. They feel they are protected from HIV or pregnancy. […] If you have a gun, you can't fear travelling at night? (Male Adult 3, Non-intervention 2).

Such findings were also echoed in the FGDs that involved male and female adolescents in the intervention area.

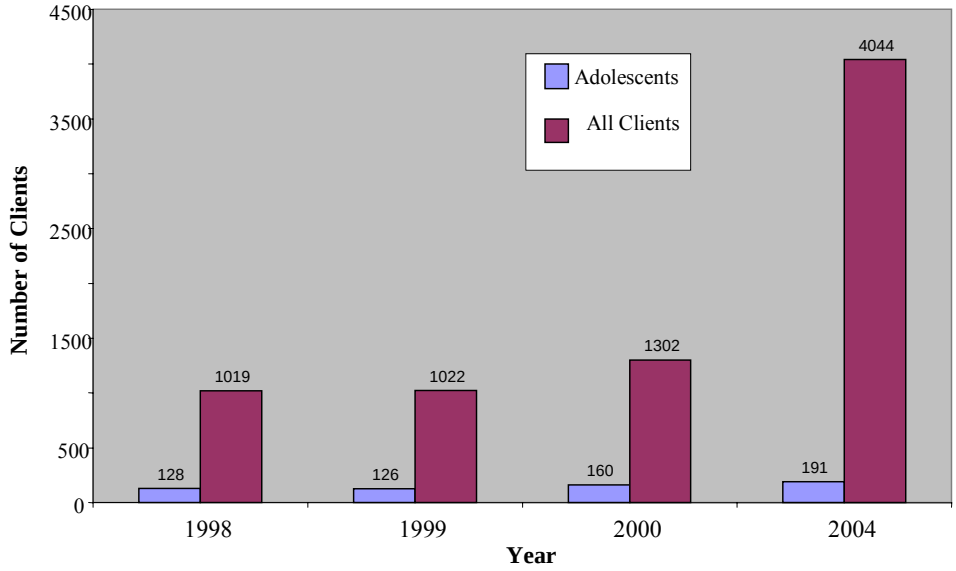
Moreover, it was found that residing in the intervention areas had no statistically significant impact on adolescents' adoption of safe sex practices. The survey results showed that while residing in the intervention areas was associated with increased likelihood to use condoms, contraceptives and having one sexual partner, residing in the non-intervention areas was associated with increased likelihood of abstinence. Notably however, residing in the intervention areas showed no difference in the likelihood of visiting clinics for SRH services from residing in the non-intervention area (Table 6.4).

Table 6.4: *Residence Area and Unmarried Adolescents' SRH Behaviour Adoption*

	Condom Use in past 6 months (%)	Secondary Abstinence (%)	Current Contraceptive Use (%)	Having One sexual Partner only (%)	Primary Abstinence (%)	Visited RH Clinic (%)
Residence Area						
Intervention	54.7	65.1	12.3	35.3	62.7	3.1
Non-intervention	42.1	67.1	6.5	32.1	65.4	3.1

The review of the service utilisation data also revealed that at one of the main intervention facilities where a good proportion of the population used contraceptives, adolescents were a small proportion of the users (Figure 6.7).

Figure 6.7: *Adolescents Using Contraceptive Methods at Mangochi District Hospital*



Source: Mangochi District Hospital HMIS Office

The qualitative results showed that like in the non-intervention areas, there was no transformation of social norms which hindered the use of SRH services by adolescents.

> Several projects teach young people about HIV/AIDS and its prevention. But people continue with their culture which can increase their risk to HIV transmission (Health Worker 6, Intervention Facility 3).

Moreover, other evidence suggested that adolescents were not adequately empowered due to short consultation periods because of health providers' fear of being stigmatised if they spent long time providing SRH counseling/services unmarried adolescents. The client exit interviews for instance revealed that about 50% of adolescents who visited intervention and non-intervention facilities had a 5-7 minute consultation time (Table 6.5).

Table 6.5: *Consultation Period for Adolescent Clients Visiting Health Facilities*

Consultation Time in minutes	*Percentages of Clients in intervention Facilities*	*Percentages of Clients in non-intervention Facilities*
5 – 7	52.2	42.7
Less than 10	27.1	33.2
Over 15	9.1	16.7

However, this consultation time was far shorter than the ones for adult and married clients which took about 15-25 minutes per client. The short consultation time for adolescents led

to missed opportunities whereby the health workers ended up not providing adequate SRH information to adolescents (Table 6.6).

Table 6.6: *Percentages of Adolescents who Received Various Amount of SRH Information at Health Facilities*

	Intervention Facilities Proportion of adolescents receiving SRH information s in %				**Non-Intervention Facilities** Proportion of adolescents receiving SRH information s in %			
	None	*Mini-mum*	*Mode rate*	*Extensive*	*None*	*Minimum*	*Mode rate*	*Extensive*
Family Planning	48	16	12	16	61.5	7.7	15.4	7.7
HIV/AIDS	44	12	12	24	15.4	23.1	30.8	23.1
Other STIs	48	8	20	16	46.2	15.4	15.4	15.4

Thus, a good proportion of adolescents ranging from about 16-62% were not given any information of SRH issues while only a few were provided with extensive/detailed SRH information for fear of stigma if they had spent optimal time with the adolescents

> Those who provide SRH services to unmarried adolescents do it faster, otherwise other staff may think that such providers encourage them to have sex if they spend a lot of time with them (Health Worker 4, Non-intervention Area 2).

The study also found that some health workers were hostile to adolescent clients who visited health facilities. Most of them objected to the provision of some SRH services to the unmarried adolescents due to social expectations that they were not supposed to have sex as one health provider at a government hospital narrated

> I wouldn't serve unmarried adolescents with family planning methods or condoms. I can serve him/her if she comes with STI. (*Interviewer posing a question: What about advice or counseling?*). It is only those adolescents who come to the clinic for antenatal or post-natal care that I can advice on family planning. To the unmarried ones, I would emphasise to them to abstain from sex (Health provider 5, Intervention Facility 5).

Other health workers also stigmatised girls who visited the clinics for services seen as being for males. The client-exit interviews revealed that some health workers discouraged girls who had come to get condoms instead of encouraging them.

> Why do you want condoms? Condoms are for boys, you need to get pills (Female Adolescent Client, 17 years, Non-intervention Facility 2).

Moreover, lack of confidentiality discouraged young people from using health facilities. While most health workers were not confidential about young people who were using SRH services, the study noted that such actions were done to their disapproval of premarital sex among young people.

> Some health workers disclose young people who come for SRH services to show their disapproval of their behaviours. Health workers think that if they are quiet after helping unmarried young person with SRH services, other health workers may think that they encourage them to have sex. Because of these attitudes, health workers share with their colleagues what they have done to their adolescent clients (Health Worker 3, Intervention Facility 1).

Besides, such health workers were also reported to have shared with the community members about young people who used SRH services to show their disapproval of the unmarried adolescents' behaviours.

> In this community, everyone knows who is doing what and when an adolescent goes to get condoms, one gets surprised to hear your parents asking you about the condoms. Health workers don't keep secret (Male FGD 2, Intervention Area 3).

Further investigation showed that these health workers' attitudes were generally due to health workers' disapproval of unmarried adolescents' involvement in sexual activity. This was reflected in statements like "*I wouldn't want my child to get contraceptives or condoms*", "*I don't want to talk about sexuality with young people because it may encourage them to have premarital sex*" and "*anyone who is sexually active at that age must be a bad child, poorly brought up by parents*" which were common in the interviews with health workers in both intervention and non-intervention areas. The health workers' disapproval was a reflection of community norms which also illegalised and stigmatised the use of SRH services by unmarried adolescents. This community disapproval was reflected in the way the women clients at MCH clinics judgementally looked at a school girl who visited the clinic (Figure 6.8).

Figure 6.8: *Women Looked Amazed Upon Seeing a Secondary School Girl Entering MCH Clinic*

These attitudes however limited the range of services adolescents could be able to access as the alternative sources available like shops were often not well placed to offer a comprehensive service package for adolescents.

Furthermore, although social traditions prohibited parents' involvement in sex and SRH education to their children, the study found that more adolescents mentioned parents as their preferred source of SRH information (Table 6.7).

Table 6.7: *Preferred Sources of SRH Information*

Source of Information	% in the Intervention Areas		% in the Non-intervention Areas	
	Male *(264)*	Female *(244)*	Male *(267)*	Female *(213)*
Parents	48.1	60.6	49.8	58.2
Peers	12.5	10.6	9.4	8.0
Teachers	4.5	2.0	6.7	6.1
Traditional counselors	0	0.8	1.5	1.9
Relatives	9.1	5.3	10.9	3.8
Youth Health Volunteers*	14.8	11.4	12.0	9.8
Health workers	1.5	0.8	1.5	1.9
Media	9.2	8.3	8.3	10.3

*( ) = n * include peer educators and youth community-based distribution agents*

Moreover, though parents' involvement in SRH education for their children was taboo, it was found that more adolescents who had discussion on various SRH issues with their parents were more likely to adopt a safe sex practices such as condom use, contraceptive use and visiting health facilities for SRH services. However, discussing SRH issues was

associated with sexual activity and increased number of sexual partners among unmarried adolescents (Table 6.8).

Table 6.8: *Percentages of Adolescents who adopted Safe Sex Practices Following Parent-Adolescent Discussion on SRH Issues*

Did you discuss these issues with family members or relatives	**Primary abstinence**		**Secondary abstinence (past 6 months)**		**Have one partner only**		**Condom Use (past 6 months)**		**Currently using Contraceptives**		**Visited SRH clinic**	
	INT	NON	INT	NON	INT	NON	INT	NON	INT	NON	INT	NON
Sexual relationships and abstinence	*	*						***	w		y	z
Yes	41.0	49.4	65.3	63.4	31.2	29.1	24.7	26.8	9.0	3.7	5.4	6.8
No	72.8	73.3	64.9	70.5	39.4	34.9	17.5	10.2	2.8	1.8	2.0	1.2
STI/ HIV prevention (condom use)	*	*				w	v					
Yes	52.0	54.9	63.6	66.7	30.7	25.0	66.7	45.2	-	-	4.4	4.4
No	74.6	78.4	68.3	68.1	45.0	50.0	35.0	33.3			1.6	1.4
How pregnancy occurs	*	*	h						*			t
Yes	50.0	52.2	55.6	68.0	-	-	-	-	9.9	4.5	3.7	6.4
No	68.4	71.6	71.9	66.3					2.5	1.5	2.8	1.5
Contraceptive methods	*	*						z		r		
Yes	39.9	45.9	63.9	63.6	-	-	24.2	30.3	16.9	13.6	7.2	6.1
No	70.9	71.8	66.1	69.2			18.8	10.6	8.9	1.9	1.8	1.9

*p<0.000, z(p<0.001), **p<0.003, r(p<0.004), ***p<0.005, t(p<0.008), h(p<0.018), y(p<0.032), s(p<0.043), m(p<0.045), v(p<0.016)

Further analysis showed that significantly more adolescents who had discussions on contraceptive methods in the intervention areas were using the contraceptives (Fisher's Exact test X^2 = 22.53, df=1, p=0.008). The results further showed that among the adolescents who had intercourse in the past 6 months, significantly more adolescents who discussed safer sex practices with family members used condoms in the past 6 months in both intervention (X^2 = 15.78, df=1, p=0.000) and non-intervention (X^2 = 4.99, df=1, p=0.026) areas.

On the contrary, significantly fewer adolescents who discussed sexual relationships with family members adopted primary abstinence than those who never discussed it in the intervention (X^2 = 49.21, df= 1, p =0.000) and non-intervention (X^2= 27.32, df= 1, p = 0.000) areas. Similarly, significantly, fewer adolescents who never had sex but discussed

contraceptive methods with their parents adopted primary abstinence in the intervention (X^2 = 41.90, df=1, p=0.000) and non-intervention areas (X^2 = 27.20, df=1, p=0.000) (Table 6.8).

The qualitative results suggested that as adolescents felt that they became aware of how pregnancy and STI/HVI infection occurred, they became careless of protecting themselves especially if they felt that they could not have these SRH problems. This encouraged some adolescents who believed that only certain groups of people were the at higher risk of certain SRH conditions like STIs or HIV/AIDS to feel free to adopt unsafe sexual practices with other people other than those classified as risk groups- "*HIV/AIDS affect older people than them. So if you have sex with them, then you must be careful*" (Female adolescent, 16 years, Non-intervention Area 4).

The interview with health workers however indicated that some adolescents' sexual behaviours were influenced by incorrect SRH information the parents might have passed on their children

> Some parents tell their daughters that they can become pregnant at certain ages not considering the onset of menstrual cycle. This makes the girls to be careless as they think they are free from pregnancy because of their age (Health Worker 7, Intervention Facility 1).

The study also found that resource centres played a role in ASRH promotion. This was evidenced in the survey results that showed that adolescents who had access to resource centres or youth club members were more likely to adopt safe sex practices (Table 6.9).

Table 6.9: *Percentages of Adolescents who adopted Safe Sex Practices Following Parent- Adolescent Discussion on SRH Issues*

Did you discuss these issues with family members or relatives	**Primary abstinence**		**Secondary abstinence (past 6 months)**		**Have one partner only**		**Condom Use (past 6 months)**		**Currently using Contraceptives**	
	INT	NON	INT	NON	INT	NON	INT	NON	INT	NON
Being a Youth Club member	a	b	*							
Yes	48.7	43.0	78.9	65.3	40.4	43.8	58.3	44.4	14.0	2.0
No	34.1	32.1	59.4	67.8	33.1	27.2	57.1	41.0	11.6	8.3
Visited resource centre									**	
Yes	50.0	40.0	69.2	67.5	35.6	50.0	75.0	42.3	46.2	6.9
No	36.6	34.3	64.8	60.0	30.8	30.9	56.3	40.0	9.9	0

*p<0.009, **p<0.002, a(p<0.004), b(p<0.032)

Further analysis indicated that significantly more adolescents who never had sex and were youth club members adopted primary abstinence in both intervention (X^2= 8.32, df = 1, p<0.004) and non-intervention areas (X^2= 4.58, df=1, p<0.032). Similarly, significantly more adolescents who were sexually active and were club members adopted secondary abstinence in the past 6 months in the intervention (X^2= 10.95, df = 1, p<0.001). Likewise, significantly more adolescents who visited the resource centres in the intervention areas were currently using contraceptive methods compared to those who never visited them (Fisher's exact Test X^2= 14.78, df=1, p<0.002).

Moreover, contrary to the community's attitudes that youth clubs encouraged adolescents to become prostitutes, most adolescents who were youth club members abstained from sex or had one sexual partner though most parents thought their associations could cause them to have many sexual partners.

According to the qualitative results, these community resource centres provided a forum where adolescents could discuss issues that hindered their adoption of safe sex practices. The discussion instilled in them some confidence and belief that they could take actions that may promote their SRH

> When we are at the youth club, we discuss several things. Through discussions we learn how to handle some of the problems we face as young people to promote our sexual health. For example, we teach other how to use condoms and this increases our confidence to use them (Male Adolescent, 17 years, Intervention Area 4).

Besides, the community resource centres also provided a forum where health workers and other community development workers could impart some knowledge and skills to adolescents that could help to promote their health.

Although ASRH community resources had a significant role in ASRH promotion, the adolescents and community members who carried out the work at community levels or supported ASRH activities respectively were stigmatised as the ones promoting premarital sex and this discouraged them. Moreover, due to cultural resistance to ASRH promotion, the community services were not accepted and supported by the whole community, a factor that can affect YFRHS success. Thus, cultural and social norms can hinder ASRH promotion.

6.2.2.2 *Staff Training and Development*

As health workers were central to YFRHS programme in Malawi (NYCoM 2001), staff training and development was reoriented to meet the needs as well as to create an attractive environment for adolescents at the facilities. While the training aimed to prepare health workers to empower adolescents to control their SRH, the study noted that the way the health workers were trained could not enable them to become agents of cultural change as social norms were the main determinants of adolescent sexual behaviours. Lack of health workers' transformation influenced their health promotion roles. For fundamentalist religious health workers, the religion and their work were intricately interwoven and hence they tried to reflect their religious principles in their daily work. As a result of these dual images (health promotion and social roles), there was no creation of a friendly environment at the clinics.

However, a review of the educational curriculum for health professionals showed that biomedical sciences courses like anatomy and microbiology formed the foundation of the

health promotion training rather than social science courses like sociology and psychology of health and illness which had much influence on health behaviours in the society. Such curriculum prepared the health workers to focus on biomedical determinants in ASRH promotion.

Moreover, while the Ottawa Charter of Health Promotion demands that health promotion initiatives should aim to enable people to control their own health (WHO 1986), a critical review of the generic training manual in Malawi revealed that YFRHS training emphasized provider empowerment rather than adolescent empowerment in its approach to YFRHS promotion as one YFRHS trainer expressed

> YFRHS training was planned for the service providers so that they can understand what the programme is all about. It focuses on what health workers should do to promote adolescent health. There is not much focus on adolescent or community role in ASRH promotion. […] We used to train health workers only until recently when we thought to include youth so that they can contribute on what they would expect providers to do to attract them to the clinics (YFRHS trainer, Intervention Area 1).

Besides, while YFRHS also emphasised life skills development such as assertiveness, negotiation and decision-making skills as tools for empowerment, other social factors such as gender roles affected the effectiveness of such skills in ASRH promotion (see chapter 5). Despite this importance of gender and rights in sexual and reproductive health issues in Malawi, the training did not prepare health workers on how they could promote gender equality among sexual partners. In other words, the health workers still could not empower female adolescents on how they can assert, negotiate or make decisions on their sexual and reproductive health. Similarly, health promoters could not train male adolescents to resist, challenge or change social norms that increased their vulnerability to SRH problems. Males could also not be trained to adapt to different attitudes such as willing to share power in relationships, a factor that can affect gender equality which could be key to SRH promotion among young people.

Moreover, despite the use of SRH education as a tool for empowering young people in ASRH promotion, it was noted that knowledge on its own could not influence behaviour change. Culture dictated adolescents' sexual behaviours in the society (see also NAC 2003).

As a result of the health workers' preparation which lacked change in critical consciousness among health promoters, observations at the clinic revealed that the clinic had more of a '*youth-friendly individual staff*' rather than being a '*youth-friendly clinic*' as there were some staff who were not happy to provide the SRH services to unmarried adolescents due to their social identities while others were comfortable with their health promotion roles

> There are some health workers who are happy to provide such services to young people. Others hesitate to do so because of their religions. […] Some health workers refuse to help the unmarried adolescents (Health Worker 4, Intervention Facility 1).

Thus, though some health workers attended the YFRHS training, some of them were reluctant to provide SRH services to unmarried adolescents due to their cultural beliefs about sexual issues. Some health workers attended the training in order to receive subsistence allowances, while others attended because they were the only staff available at the facilities. This affected their commitment to the ASRH promotion. Evidence also showed that health workers who had adolescent children avoided counselling them on SRH due to culture (see case study of a health worker mother below)

Case Study of Life of YFRHS Provider and Her Daughter

There was female health worker working at one of the facility in the study area whose daughter became pregnant while in form two at one of the secondary schools in Malawi. An interview with the provider's daughter who had now delivered showed the role of her mother in promoting SRH in her family.

Interviewer: Your mother is a nurse, what advice has she ever given you on preventing yourself from becoming pregnant?

Respondent: My mother never talked about sexual issues to me. She only shouts at me whenever she hears that I was with a boy on my way from school. […] I have never heard her talking of such issues to my brother or sisters either. Even when I was pregnant, my mum sent me home so that my grandmother and aunts could give me advice on pregnancy care though she helps a lot of pregnant women at the clinic.

Interviewer: What do you think is the reason for your mother not to discuss or advise you on such issues?

Respondent: I am not very sure. Aaah, may be she thinks if she tells me to use contraceptive methods or condoms, I will think she is encouraging me to go out and have sex. But also, as she is a member of women guild in our church, she may be thinking that telling me to use such services could be against her faith. I am not surprised though as all my friends tell me that their parents do not advise them on sexuality. If they want tell them, they give them as religious advice.

Extract from interview with one of the girls 17 years, whose mother was YFRHS provider in Intervention Area 2

Besides, it was noted that despite the fact that health workers pushed SRH promotion when they worked in their hospitals, they participated in promoting unsafe sex practices in the communities

> Ooh yes, some health workers visit our initiation camps and they also encourage the initiates to do what they have been advised them including '*kuchotsa fumbi*' (Initiation Camp Guardian, 19 years, Intervention Area 1).

All this evidence shows that unless the training of health workers make them become effective cultural change agents, health workers could not effectively promote ASRH in culturally-conservative societies.

6.3 ***Logistic Regression Results: Modelling Predictors of SRH Behaviour Adoption***

The logistic regression analysis based on the independent variables that were significantly associated with adoption of safe sex practices at the univariate level revealed that social norms were associated with adoption of unsafe sex practices in both intervention and non-intervention areas. The dependent variable was adoption of safe sex practice. The proxy indicators for safe sex practice were defined as abstinence among those who never had sex, contraceptive use/condom use or secondary abstinence use among those sexually active. Having one sexual partner was excluded as the partners had not tested for HIV and hence were not aware of their status. Independent variables included all the socio-demographic and health services factors.

The logistic regression results showed social norms which could disempower adolescents to adopt safe sex practices were associated with less likelihood of adopting safe sex practices among adolescents (see Chapter 5 and 6). However, interventions that were at odds with the social norms were associated with increased likelihood of adopting safe sex practices (Table 6.10A and 6.10B).

Table 6.10A: *Logistic Regression Analysis Showing the Effects of Variables on Likelihood of Adopting Safe Sex Behaviour in Intervention Area (Backward Stepwise LR)*

Variable	***β***	***SE***	***Wald Statistics***	***Odds Ratio (95% CI)***
Currently Schooling				
No (r)				1.00
Yes	0.866	0.386	5.030	2.377 (1.115-5.065)**
Educational level completed				
Primary (r)				1.00
Secondary	1.821	0.480	14.387	6.181(2.412-15.847)*
Ever had boy/girl friend				
No (r)				1.00
Yes	-1.328	0.497	7.139	0.265(0.100-0.702)
Access to SRH services (condoms)				
Yes (r)				1.00
No	-2.580	0.453	32.485	0.076(0.031-0.184)*
Hosmer and Lemeshow Test				X=97.542, df=5, p=0.277

Note: p values: *p<0.000, **p<0.025, ***p<0.008
r = reference

Table 6.10B: *Logistic Regression Analysis Showing the Effects of Variables on Likelihood of Adopting Safe Sex Behaviours in Non-intervention Area (Backward Stepwise LR)*

Variable	***β***	***SE***	***Wald Statistics***	***Odds Ratio (95% CI)***
Sex				
Female (r)				1.00
Male	1.360	0.671	4.111	3.896 (1.046-14.503)*****
Discuss using safer sex with parents				
Yes(r)				1.00
No	-1.987	0.672	8.751	0.137(0.037-0.511)**
Currently schooling				
No (r)				1.00
Yes	1.251	0.490	6.520	3.493(1.337-9.124)***
Had intention to abstain from sex				
Yes (r)				1.00
No	-1.071	0.496	4.666	0.343(0.130-0.906)****
Could ask partner to use condom				
Yes (r)				1.00
No	-3.054	0.509	36.060	0.047(0.017-0.128)*
Hosmer and Lemeshow Test				X=1.504, df=7, p=0.982

Note: p values: *p<0.000, **p<0.003, ***p<0.011, ****p<0.031, p*****p<0.043 (r = reference)

The tables above show that social norm-related factors were associated with adoption of sex practices that were socially expected in the societies. For instance, having sexual partners was strongly associated with low adoption of safe sex practices among adolescents in the intervention areas (OR=0.265, 95% CI= 0.100-0.702, p<0.008). As explained earlier in chapter five, boy-girl sexual relationships were considered like mini-marriage where unprotected sex was the norm. Similarly, gender caused asymmetry in safe sex practice adoption. For instance, compared to the females, the odds of using protective measures among boys was higher (OR=3.896, 95% CI= 1.046, 14.503, p<0.011). This was probably due to the fact that males control sexual issues and hence their decisions to have protected sex were implemented unlike if the same decisions were made by females.

Besides, the logistic regression results revealed that interventions that were at odds with the social norm-related behaviours were associated with adoption of safe sex practices (Tables 6.8A and B). For instance, education which can increase young people's autonomy and enable them to read SRH leaflets was associated with adoption of safe sex practices among adolescents (boys and girls) in both intervention and non-intervention areas. Compared to the reference group (those who were not schooling), the odds of adopting safe sex practices were significantly higher among the adolescents currently schooling in the intervention (OR=2.377, 95% CI= 1.115, 5.065, p<0.025). In the non-intervention areas, compared to those who were not schooling, the odds of adopting safe sex practices among those schooling was higher (OR=3.493, 95% CI= 1.337, 9.134, p<0.011).

Compared to the reference group (those who attained primary school education), the odds of adopting safe sex practices were significantly higher among the adolescents who attained secondary school education in the intervention (OR= 6.181, 95% CI = 2.412, 15.847, p<0.000).

Moreover, life skills were also associated with adoption of safe sex practices. For instance, compared to those who could ask (assertive/negotiate) their partners to use

condoms in the reference group, the odds of condom use was significantly lower among those who could not ask their partners to use condoms (OR=0.047, 95% CI= 0.017, 0.128, p<0.000). Likewise, the odds of adopting safe sex practices among the adolescents who never discussed safer sex practices with their parents was significantly lower as compared to those who discussed SRH issues with their parents (OR=0.137, 95% CI= 0.037, 0.511, p<0.003). Similarly, the odds of using SRH preventive measures among the adolescents who never had intentions to abstain from sex was significantly lower compared those who had intentions to abstain from sex (OR=0.343, 95% CI = 0.139, 0.906, p<0.031). These results show that lack of life skills is associated with disempowerment among adolescents.

Lastly, the regression results indicated that access to SRH services was associated with adoption of safe sex practices. For instance, compared to the adolescents who had access to SRH services as a reference group, the odds of adopting safe sex practices was lower among adolescents who had no access to SRH services in the intervention areas (OR=0.076, 95% CI= 0.031, 0.184, p<0.000). While this could be attributed to access to services, the results from the previous chapter suggest that the impact of YFRHS in empowering the communities to support ASRH activities might also have played a significant role.

Goodness-of-fit tests also supported the model as being worthwhile in explaining the predictors of safe sex practice adoption in the intervention areas (Hosmer and Lemeshow Test: X^2= 7.506, df=6, p=0.277) and non-intervention areas (Hosmer and Lemeshow Test: X^2= 1.504, df=7, p=0.982). Thus, these logistic regression results prove that social-norm related determinants of sex practices influence the adoption of safe sex practices among unmarried adolescents in Malawi.

6.4 ***Conclusion***

All in all, the evidence in this chapter shows that the way facility-based YFRHS were implemented in Malawi was not effective in promoting SRH among unmarried adolescents. Adolescent sex practices were largely influenced by social and cultural

norms. As such, promoting ASRH is therefore more complex than simply providing accessible SRH services (Smith 1993; Cowan 2002; Kirby 2002b).

Chapter Seven

The Capacity of YFRHS for Unmarried Adolescents' SRH Promotion: A Synthesis of the Evidence from Rural Malawi

7.0 *Introduction*

In this study, the capacity of facility based YFRHS to promote and facilitate the adoption of preventive measures to reduce early pregnancies and STIs including HIV/AIDS among unmarried adolescents was examined. The bivariate and logistic regression analyses indicated that there are no significant differences in the adoption of safe sex practices between adolescents in the intervention and non-intervention areas, even though there were some safe sex behaviours which were more prevalent in the intervention areas. It is however unlikely that the differences could be ascribed to availability of YFRHS only because the logic regression analyses indicated that area of residence was not a predictor for adoption of safe sex practices (Tables 6.10).

However, the qualitative results reveal that ambiguous normative culture, stigma, gender roles and other social norms are important determinants in the adoption of safe sex practices in culturally-conservative societies of rural Malawi. This implies that although YFRHS might provide an attractive environment for adolescents to use SRH services (NYCOM 2001); the increase in access to SRH services alone is insufficient to promote ASRH. Cultural norms and values related to sexual behaviour may reduce adolescents, communities' and health workers' agency for their role in ASRH promotion.

Based on the above findings, I argue that unless the facility-based YFRHS have the capacity to transform the both the social identities influencing the adoption of unsafe sex practices as well as the ambiguities in the social norms that give rise to social identities, health facilities may not effectively promote ASRH among unmarried adolescents in culturally-conservative societies. This means that for effective interventions are to be designed to address ASRH problems there is a need for public-health interventions to pay greater heed to the social and cultural context within which adolescent sexual behaviours occur (Richens, et al, 2003; Barnet and Parkhurst 2005; Lesch and Kruger 2005; Roberts, et al, 2005; Adimora and Schoenbach 2005). In order to expand on the above argument

and respond to the research questions, this chapter addresses four critical issues which arose during the research process

(a) *What roles do social identity-related factors such as gender, normative culture and stigma play in influencing unmarried adolescents' sexual behaviours?*

(b) *What does the study add to our understanding of gender identities and economic development in influencing the vulnerability of unmarried adolescents to SRH problems?*

(c) *What are the strengths and limitations of facility-based YFRHS in addressing social identity related determinants of ASRH in culturally conservative societies?*

(d) *How should facility-based YFRHS be conceptualised in order to address social identity-related determinants of adolescent sexual behaviours?*

Lastly, the chapter concludes that unless the health facilities have the capacity to effect change in the social norms and values associated with sexual identities and influencing adolescent sexual behaviours, facility-based YFRHS cannot be influential in promoting SRH among unmarried adolescents in culturally-conservative societies.

To understand the role of social and cultural values and the capacity of facility-based YFRHS in ASRH promotion, the discussion is informed by the understanding of adolescent sex practices in Malawi through social identity theory. This is because effective health programmes require a grounded understanding of the context in which they are implemented (Wynd et al, 2007). The social identity theory postulates that social and cultural values not only influence individuals' behaviours, but also shapes the environments in which sex practices occur. The discussion is further enhanced by an understanding of the Ottawa Charter for Health Promotion (WHO 1986a) as an overarching framework (see Chapter 2).

7.1 ***Social Identities and Adolescent Sexual and Reproductive Behaviours***

7.1.1 *Ambiguous Normative Culture - Multiple Social Identities*

Culture plays a vital role in determining the health behaviours of individuals, families, communities and the health facilities, particularly in Africa, where the values, norms and attitudes of the societies significantly influence people's behaviours and actions (Airhihenbuwa and DeWitt Webster 2004; CRH 2005). In most societies, sexual behaviours consist of practices deeply embedded in the culture (Rival et al., 1998). Mazrui (1986: 239) defines culture as 'a system of interrelated values active enough to influence and condition perception, judgment, communication, and behaviour in a given society'. Culture is the foundation of social identities among various ethnic or social groups. Culture is shaped by external and internal influences. External influences may be in form of effects of media or migration; while internal influence may include change initiated by people within the society.

Culturally determined sexual norms define the expected behaviours, values and attitudes that influence and shape actions of communities, adolescents and health workers towards adolescent sexuality and sexual practices (Praditwong 1990; Paiva 1993; Cash and Anasuchatkul 1995; Childhope and NESA 1997; Chimbiri 2007). These norms provide sexual identities of people in the society (Airhihenbuwa and DeWitt Webster 2004; Neema et al, 2006). Culture therefore has implications for people's roles and actions in health promoting-related practices (Brody 1987; Lupton 1994; Hahn 1995).

While cultural norms create universal social identities in a particular social group (Airhihenbuwa and De Witt Webster 2004), the ambiguous normative culture in Malawian societies creates multiple social identities that can impact on ASRH (see also Poulin 2006b; Wight et al 2006). As defined earlier (section 1.2), ambiguous culture means the existence of different but parallel sexual values, beliefs and practices within one society. The ambiguous culture can hinder adolescents', communities' and health workers' efforts towards ASRH promotion. For instance, because the same culture that prohibits premarital sex also encourages premarital sex as symbol of transition from childhood to adulthood, such cultural ambiguity makes people to adopt multiple sexual identities (McKoy 2001; Clarke-Hines 1993). The multiple sexual identities influence adolescents and communities

to adopt or support different sexual behaviours in different situations depending on the social groups they are involved in. On the other hand, the multiple identities related to sexuality can make health workers to act as moral guardians in traditional settings and health promoter in the hospital settings (see 7.2.2). Because some social groups' norms tolerate risky sexual practices (FHI 2000b), this means that ambiguous multiple identities in Malawi commonly increase adolescents' risk to SRH problems. Alternatively, the ambiguous norms can make adolescents develop lifestyles that can either protect their SRH or make them more vulnerable to SRH problems depending on the norms they adopt (Tajfel 1981). Despite this vulnerability, ambiguous culture makes promotion of certain SRH services that target unmarried adolescents contentious in the society. The norms in some institutions hinder adolescents' rights to protect their SRH regardless of their SRH risk awareness (Nowska 1996; UNFPA 2003).

Multiple sexual norms can also confuse adolescents on the appropriate sexual behaviours as various norms advise adolescents to do different behaviours and yet all the norms are passed to young people and also reinforced by one society. This was evidenced in the study as most adults interviewed stated that they could not allow early childbearing among their daughters and yet they allowed early marriages and importance of childbearing was emphasised to young girls (see CRH 2004).

Moreover, globalisation effects have further worsened the confusion in the communities' roles in socialisation of young people due to the increase in the emerging social institutions. Due to globalisation, new institutions such as the media, western-oriented education and religious institutions have emerged. These institutions promote adolescent sexual beliefs and practices that contradict the local sexual norms. In some instances, traditional advisors on matters of sexuality have handed over their roles to these modern structures (Caldwell et al., 1998; Munthali et al., 2004) but yet these institutions are not well prepared for the role. Thus, globalisation has suppressed the traditional socialisation institutions, it has also created a vacuum and a confusion in the socialisation process as there is no standardised socialisation process on sexual behaviours due to different beliefs and values of the various institutions. This vacuum could however create opportunities for health promotion as health sector-initiated collaborations can help to reduce the ambiguous sexual norms by

empowering the institutions with appropriate sexuality and sex messages that can promote ASRH.

Furthermore, young men and women have different knowledge or skills regarding their sexuality and expected sexual behaviours imparted to them (CSR 1997; Caldwell et al., 1998; Neema et al., 2004). This homosocialisation leads to the adoption of different and yet parallel and conflicting sexual identities by boys and girls that affect their SRH (Wight 2008). Homosociality as used by Gagnon and Simon (1974) describes the way in which male and female adolescents generally grow up in separate social worlds as homosocial groups. In homosocialisation, understandings of sex are primarily learnt and shaped by same sex peers, and adolescents' sexual identities tend to be built on other non-sexual social identities that boost gender identities and self-esteem (Wight 2008). Homosociality is therefore different from homosexuality although homosexuality might be an expression in some homosocial groups. Homosocialisation can result in structural differences in sexual roles based on what roles or behaviours are allowed or not allowed in relation to one's sex in the society (Connell 2000; Gupta 2000; 2002; Ervo and Johansson 2003; Wight 2008) and therefore institutionalises inequality between males and females in sexual relationships.

Because of these ambiguous norms that provide conflicting information, adolescents may be influenced to adopt unsafe sex practices (Irwin, et al 1994; Caldwell *et al*. 1992). This finding is not unique to Malawi as Missie (2002) writing about Uganda also argues that the current conflicting messages about adolescent sexuality, with the promotion of sexual involvement on one extreme and the urging of chastity on the other make the adolescents feel guilty, uncertain or indecisive about their sexual lifestyles.

Moreover, because males and females are homosocialised, males and females attach different values to certain sexual behaviours and that can affect their SRH practices. This means that health promotion initiatives that promote gender equality without addressing the social norms that guide boys and girls' behaviours are likely to be resisted. In this case, therefore, YFRHS need to advocate heterosocialisation of male and female adolescents in all institutions including schools, homes and others to instil equality in young men and women from young age.

Adolescent identity development also requires the exploration of contrasting values, attitudes and behavioural norms of various social groups (Erikson 1968; Shrake and Ree 2004). Due to this, social identity development process is more likely to expose the adolescents to SRH risks as they may tend to move from one social group to another and hence adopt various behaviours along this phase of life (Phinney 1992; Roberts et al, 1999).

The multiple sexual identities resulting from ambiguous normative culture can affect communities' roles in ASRH promotion. Due to multiple social norms, the process of adolescent socialisation by the communities may be ambiguous. The multiple memberships in various social institutions - family, school, church or mosque -create a dilemma about what is imparted to young people during socialisation and what behaviour is to be reinforced by any particular socialisation agent. Furthermore, most community members who play part in socialisation of young people change their allegiances according to social group they are: "*Many people change their positions according to the role they take in different institutions. If they are in churches, they emphasise on abstinence; but when time for initiation rites comes, the same people encourage young boys to have sex as part of the rite*" (Youth Zone Coordinator 2, Intervention Area 3); this can confuse adolescents on the behaviour to be adopted as the same person reinforcing one behaviour also reinforces the other.

Besides, ambiguous normative culture creates tensions in the ways communities and health providers can provide support to ASRH promotion. The presence of ambiguous cultures means that there are likely to be reinforcers and opponents of certain sexual behaviours within one society. The resistance of certain institutions to provision of certain SRH services can hinder adolescents' adoption of some safe sex practices due to limited access if the services are not supported by health workers or institution's desire to be approved as a 'moral' by the society. As such, community members and health workers are more likely to resist providing social support to unmarried adolescents because of the fear of stigma by association (Seeley et al., 1993a; Hatchett et al., 2004; Rankin et al, 2005a; Holzemer et al, 2007). Moreover, where the health workers and communities hold social norms which contradict the western health promotion ideologies (Beninguisse 2004), these norms discourage them to promote or participate in certain behaviours that can promote ASRH.

Thus health workers and communities might not provide some SRH information and services to unmarried adolescents in order to uphold their own social and moral identities although the provision of such services can promote SRH among unmarried adolescents. Thus, the ambiguous culture and resultant multiple social identities do not provide a conducive environment for the communities and health workers to provide consistent social support and other services that can promote ASRH.

Ambiguous normative culture can also negatively affect the political environment in which ASRH promotion is carried out. This culture can make politicians and legislators adopt different but conflicting attitudes towards the SRH promotion among unmarried adolescents. Due to ambiguous culture, politicians and legislators may also align themselves with different social groups some of which could have norms that do not promote SRH among unmarried adolescents. These attitudes can influence these people including health professionals to refrain from supporting ASRH promotion initiatives despite their professional responsibility or awareness of the risks adolescents face if they cannot access SRH services. This finding is not unique to Malawi. The former health minister of Zambia Dr Luo also expressed the view that despite being a health professional, it is difficult for her to act in a way that is incongruent with her culture: "*in my country, it is a taboo for a person like me to discuss sex with someone younger*" McNeil 2002: A11). Besides, the multiple social identities could lead to tensions or problems in legislation or policy making if legislators or politicians have different views on certain SRH issues related to unmarried people. If some politicians do not support provision of condoms to unmarried adolescents for instance, policy formation, advocacy or budgetary allocations related to ASRH may not be supported by the politicians and that can affect the success of ASRH promotion (Garrett 2000).

Overall, ambiguous sexual norms and resultant multiple social identities can create a risky environment for ASRH (Barnett and Whiteside 2001). The ambiguous culture and conflicting cultural norms undermines adolescents' autonomy, agency and decision-making as well as the health sector's and communities' capacity and support for SRH promotion activities for unmarried adolescents. Although addressing the cultural determinants of sexual behaviour is always challenging, in Malawi the particularly ambiguous normative culture presents a very complex challenge to the implementation of YFRHS.

7.1.2 *Structural Gender Asymmetry: Homosociality, Power Control and Subservience*

Gender roles and values underlie sexual behaviour and contribute to the vulnerability to SRH problems in most societies (WHO *et al*, 1995; UNAIDS, 1997; Connell 2000; Gupta 2000; Campbell 2003). Gender is defined as the societal beliefs, customs and practices associated with masculine and feminine characteristics, behaviours and roles (UNDP (2003). Gender roles define what men and females can do in the society. While gender affects all aspects of people's lives, this section pays a particular attention to the impact of gender on adolescent sexual behaviours in Malawi. Gender in sexuality identifies the social roles, expectations and relations associated with being male or female (Connell 2000; Gupta 2000; Campbell 2003). These gendered roles and expectations create structured gender asymmetry which can increase SRH risks

As in other countries in sub-Saharan Africa (Caldwell et al, 1998; Kim et al, 2001; Dreze and Murthi 2001; Mesfin 2002), roles of males and females in Malawi are culturally constructed and highly differentiated based on gender (Chimbiri 2002; 2007). Coherent with other literature in Malawi (CSR 1997; Munthali et al, 2004; Chimbiri 2002; 2007), the findings of this research shows that gender role stereotypes cause structural gender asymmetry at individual, society and state levels which can affect ASRH promotion.

At individual level, homosociality and constructs of masculinity/femininity cause structural gender asymmetry that can increase adolescents' vulnerability to SRH problems (Oheneba-Sakyi and Takyi 1997; Wolff et al, 2000; Walker and Gilbert 2002; Mesfin 2002; Dahlback et al 2003).

As the predominant gendered role in sexual issues in Malawi is hegemonic masculinity (Hickey 1999; Save the Children 2000; see also Abraham et al., 1999), this can also have implications for ASRH promotion. Hegemonic masculinity in any society is based on power and designed to oppress women as well as other men (Connell 1995; Morrell 2001). Due to the hegemonic culture, males are powerful while females become subservient in heterosexual relationships (Stewarts et al, 1998; Chimbiri 2002; 2007). What I interpret as female subservience is described as humility among the girls in the Malawian context, and is a component of quality in the Malawian notion of a "good woman". In this way, the

notion of humility is actually a form of oppression that undermines the female adolescents' autonomy in SRH as it encourages female passivity in sexual issues. Furthermore, due to the hegemonic culture, other measures that can promote the socioeconomic status of females like education and employment cannot guarantee females' autonomy to control their SRH in heterosexual relationships (Seeley et al., 1993b; 1994; Kabeer 1995).

Moreover, because male and female adolescents are socialised differently - males to control sexual matters and females to be subservient (see Munthali et al., 2004), girls do not have autonomy over their SRH. Besides, because of the importance of social identities, adolescents tend to adhere to the gendered roles, some of which disempower them from SRH promotion (Kaler 2003; 2004; Hunter 2005; Chimbiri 2002; 2007). Most adolescents take actions that can raise their social status regardless of the associated risks of the actions (self-esteem, respect, reputation). For instance, masculinity as promoted in most societies can increase males' vulnerability to SRH problems as Chege (2005:2) explains:

> Social construction of masculinity compromises men's health by encouraging men to equate a range of risky behaviours with manliness and to regard health-seeking behaviours as unmanly. Masculine ideologies encourage multiple sexual partners and more sexual activity, and promote beliefs that lead to negative condom use attitudes and inconsistent condom use.

Similarly, the norms make girls to see themselves as passive receptacles of boys' sexual passions (Hickey 1999; Olotu-Leigh et al, 2001) as they are socialised to be subservient to male partners in sexual matters (CSR 1997; Chege 2005) and hence do not control sexual decisions including use of safe sex practices. Moreover, due to culture, boys and girls are more likely to adopt their masculine and feminine sexual roles as many boys could feel stress if they are unable to live up to the expected norms of manhood (Barker 2000; Dahlback et al 2003). Similar findings are also reported in other countries where girls tend to lose their SRH autonomy in order to be regarded as 'nice girls' (Cowie and Lees 1987; Holland et al, 1998), while boys impose their hegemonic masculinity in sexual matters as that entails 'clever boys' (Wight 1994).

Additionally, although the SRH clinics are more female-friendly because of their set-up and hence could facilitate girls' access to SRH services (Chirwa and Kudzala 2001), male dominance in the control of SRH issues in heterosexual relations can undermine the female

adolescents' autonomy over their adoption of safe sex practices. Similar observations have also been reported in Mexico (Barbeiri 1993) and most African societies (Oheneba-Sakyi and Takyi 1997; Dreze and Murthi 2001; Mesfin 2002) where males' control hinders females' adoption of safe sex behaviours. In this way, constructs of masculinity and femininity cause structural gender asymmetry that leads to inequalities in SRH decision-making (Chege 2005; CRH 2005; Kalipeni et al, 2007) which can increase adolescents' vulnerability to SRH problems (Wolff et al, 2000; Walker and Gilbert 2002).

Homosociality on the other hand supports adolescents to carry out some risky sexual practices in order to impress their peers (Wight 1994; 1996). As boys' prime concern in homosociality for instance is not that of their female sexual partners but rather their self-esteem among their male peers (Gagnon and Simon 1974; Wight 1994), the notion of individual social achievement may override the importance of protecting themselves and their partners regardless of their awareness of threat of their sexual behaviours in asymmetric sexual relationships (Wight 1994; 1996).

Moreover, due to social allegiances and commitment to the society's norms (Tajfel 1981; Turner 1982; Cowie and Lees 1987; Holland et al, 1998; Fekadu 2001; Taffa et al, 2002), adolescents are reluctant to oppose or contravene the dominant gendered sexual roles and expectations in these relationships. Girls for instance find it more difficult to suggest the use of safe sex practices as that action cannot be applauded by their peers (Kaleeba et al., 1991; Chimbiri 2007), yet their male partners may have other sexual partners (Oppenheim-Mason 1994; Kaler 2003; Hunter 2005). This homosociality-related structural gender asymmetry increases adolescents' vulnerability to SRH problems (Wight 1994; 1996; 2008; Chimbiri 2002; Dahlback et al., 2003).

Apart from the effects of masculinity/femininity and homosociality on adolescents' SRH agency, gender norm stereotypes can also affect the communities' capacity to promote SRH of unmarried adolescents. For instance, while the importance of gender equality in health promotion has been emphasised in Malawi (NYCoM 2001; Chimbiri 2002) and other countries (Hutton 1992; Kalnins et al, 1992; Dixon 1993; Rissel 1994), most societies in Malawi continue to socialise girls and boys based on expected gendered roles. However, as socialisation in Malawi empowers young men to control sexual and reproductive matters

and encourages females' subservience in such matters (Hickey 1997; Chimbiri 2002; Munthali et al, 2004), this means that the communities continue to promote structural gender asymmetry between males and females which can increase SRH risk. Such findings also concur with other studies that reveal that females in most developing countries are constrained by gender norms to control their SRH (Grundfest Schoepf 1991; Oppenheim-Mason 1994; Topouzis and Hemrich 1994).

The gender stereotype can also make some community members with traditional views of gender to resist ASRH interventions aimed to empower females in SRH decision-making. Some traditionalists may also not provide support to young women who are sexually abused as such abuse would be considered normal among them (Kaleeba et al., 1991). Such beliefs are compounded by the local belief expressed during the interviews that "*mkazi azipilira*" meaning "*females should be able to bear any hardship perpetuated by their male sexual partners*" (Male Adult 2, Non-intervention Area 1). Due to these community beliefs, adolescents may not report any sexual abuses as they consider them as part of community life. In this way, gender role stereotype makes adolescents and communities to tolerate gender-based practices. These practices however can increase adolescents' vulnerability to SRH problems as some sexual abuses can lead to unwanted pregnancies or STIs including HIV/AIDS.

Although a review of several studies reveal that incorporating males into SRH programmes can make such programmes more effective in promoting service use among males and females (Becker 1996; Mayhew 1996; WHO 2007), the results here show that this cannot always be the case as gender and sexuality are deeply rooted in culture (see also Rival et al., 1991). Gendered roles of males and females are socially acceptable and reinforced by people of both sexes, a sign that it is part of their normal life. This is also clearly exemplified in other studies in Malawi that show that some girls reported that it is better to risk getting pregnant rather than ask their male partners to use condoms, which is considered a man's role (CSR 1997, Hickey 1997; Kornifield and Namate 1997; Chimbiri 2002). Moreover, in most societies, females' involvement in what is seen as males' issues is considered as transcending the boundaries of appropriate femininity and that could arouse male anger and violence (Schoepf 1988; Kaleeba et al., 1991: Chimbiri 2002) because that is viewed as undermining the males' authority (Chimbiri 2002; 2007). This

shows that gender norms are not easily amenable to change. This therefore means that unless YFRHS transform the cultural norms that oppress female autonomy in SRH promotion, the mere involvement of males in SRH programmes may not be effective to increase the females' autonomy to control decision-making in SRH issues (Mustakova-Possardt 1998; 2000). Thus, unless social transformation of gender norms occurs, the community acceptance of the gendered roles in sexuality are more likely to continue to disempower female adolescents regardless of male involvement as narrated in Uganda.

> ... we live in culture where men control sex. In these culture, even if you turn to your mother and return to her beaten and swollen saying you won't go back to your [sexual partner] because you refuse to sleep with him, she will tell you to go home, to get out. How can you not have sex when he wants to have sex? (Kaleeba et al., 1991:50)

In this case, health promotion that fails to conscientise the society is less likely to be effective in addressing the gender inequality that disempowers females in SRH promotion in the society (Freire 2000).

Gender role stereotypes can also influence the political environment in which national plans for ASRH promotion are made. Political systems can reinforce gender-based disparities among unmarried adolescents through formal laws and policies. Legislation related to education policies for pregnant girls in Malawi for instance has been reinforcing expulsion of pregnant girls from school until recently (1994) when they are allowed to continue with their education after delivery. Such policies were informed by the stereotype that girls who became pregnant whilst schooling were sexually immoral; contrary to social expectations. Due to the violation of social norms, such girls were not allowed to return to school after delivery. On the contrary, the policies did not punish the 'responsible' boys probably because socially boys are expected to have sex and are applauded for impregnating.

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Similarly, legislation regarding the age of marriage for girls while there is none for boys (Malawi Government 2004) just reflects the gendered social role that expects females to have children. The gender stereotype that disempowers females is also reflected in the legislation that empowers parents to consent marriage of their daughters when they are 13 years and below (ibid.) while such provision does not exist for boys. Such findings were

also reported in other sub-Saharan countries where there were laws that allowed early marriages among girls and not for boys (Mati 1989; Noble et al., 1996; Kishor and Neitzel 1996; Meekers and Calves 1997). These laws cause girls' greater vulnerability to SRH problems as compared to their male counterparts (ibid; UN IRIN 2004).

Moreover, as Malawian girls often marry considerably older men (CSR 1997; CRH 2004), such girls are more likely to have less power to negotiate for safe sex practices (AGI 1995; Noble et al., 1996; Kishor and Neitzel 1996) besides that the older men may have other sexual partners. Besides early marriages, the resultant early school drop-out hinder female adolescents' education which in the long-term compromises females' SRH autonomy (Jejebhoy 1995; Basu 2002; United Nations 2005) due to unemployment because of poor educational qualifications.

Furthermore, in societies where politicians do not support gender equality in sexual matters, there can be difficulties to approve resource allocations or conduct advocacy of programmes that aim to empower females (Campbell and Williams 1999; Lush 2000; Schneider 2002; Parkhurst and Lush 2004). Also, in societies where gender issues are contentious, some politicians may avoid reference to such issues as that would threaten their popularity even if they personally are in support of it (Twaddle and Hansen 1998; Spence 1999). This political environment can fail programmes that promote gender equality in SRH and this can perpetuate gender asymmetry in SRH control (World Bank 1994; Standing 1997; WHO 1998b). However, the importance of political environment in gender equality in SRH promotion is evident in Senegal, Uganda and Zambia where political commitment resulted in reduction in the HIV/AIDS incidence and prevalence rates among males and females (Diop 2000). It is therefore obvious that political environment that does not support gender equality policies can disempower females to have SRH autonomy

7.1.3 *Gender, Economics and Vulnerability*

Economic developments in the fishing industry in Malawi have also changed gender identities of both males and females in ways that can affect ASRH. While research on transactional sex in the sub-Saharan Africa for instance suggests that males are the ones who could induce sex trade (Nyanzi et al, 2001; Nzyako et al, 1997; Hunter 2002, Luke

2002; 2003; Zelizer 2005), this study shows that male adolescents are enticed by females for transactional sex. As some businesswomen have left their traditional reproductive roles to join the productive roles, they try to build up their social identities in the new social roles using transactional sex (Moser 1993; March et al., 1999). These businesswomen use their sex to enhance their productive role identities through the growing of their businesses. On the other hand, male adolescents maximize their fish sales on one hand and gain associated status by having sex with the businesswomen who are highly regarded in the society. These results concur with another study in Malawi that reported that businesswomen who purchased their goods outside Malawi have sexual intercourse with young businessmen so that the young men would accommodate the women in their hotel rooms and thereby the women avoid the accommodation costs (CSR et al, 2004). The associated increased social status acquired by young men and the economic gains by businesswomen means that both businesswomen and young people are more likely to continue in unsafe transactional sex. Young men consider the use of condoms as unnecessary due to the acquired social status associated with their sexual relationships with the 'high status businesswomen' (Wight 1998; Wojcicki and Malala 2001; Hattori and Nii-Amoo Dodoo 2007); as commonly reflected in the interviews that "*zabwino sadyera m'pepala*" ("*you don't eat nice things whilst it is in its wrapper*"). While research suggests that social norms restrict women to suggest condom use in Malawi (Chimbiri 2002; 2007), this study also shows that female traders initiated unprotected sex (no condom use) for economic gains - in this case with young fishermen in order for the female traders to buy their fish at lower prices. In this way, the market economy has contributed to disempowerment of the young people and businesswomen to control their sexual health and this can increase SRH risks for both.

Moreover, while several studies show that females had transactional sex in order to meet their basic survival and subsistence needs (Nzyako et al, 1997; Nyanzi et al, 2001; Hallman 2004; Hunter 2002; Lerclerc-Madlala 2003a; Masanjala 2007), the findings in this research show that businesswomen are motivated to have sex to maximise their business profits in order to raise their social identities in the society and business community (see also Cornwall 2002; Wardlaw 2004). Similar observations were made by Poulin (2007) who noted that transactional sex now extend beyond meeting basic survival needs in the face of poverty towards commodification of sex. Surely, the ascendancy of the market economy

has altered the social identities by changing the power dynamics of sexual relations between males and females (Ankomah 1992; Lerclerc-Madlala 2003a). These changes in economic identities have resulted in the reconfiguration of gender relations in the society (Cornwall 2002; Wardlaw 2004) in a way that can increase boys' and businesswomen's vulnerability to SRH problems. Therefore, this study's findings add to knowledge on the association between economic development, social identities and the vulnerability to SRH problems in Malawi.

Transactional sex within the business circles is also likely to have a great impact on ASRH. Due to the lower prices received for fish sales in these transactions; that could affect the male adolescents' livelihoods which might in the long term impact on their vulnerability to poor health (Dahlgren and Whitehead 1991). Moreover, because businesswomen have frequent travel in their business endeavours, they are more likely than others to have multiple sexual partners (Morris and Kretzscmar 1997; Luke 2002; Dunkle et al, 2004; Labonte and Schrecker 2007) as well as multiple concurrent partnerships (Luke 2002; Dunkle et al, 2004). This sexual concurrency could increase rates of STI/HIV transmission as large numbers of people might be sexually connected at any given time (Morris and Kretzscmar 1997). In this case, boys' involvement in sexual relationships with businesswomen is could increase their STI/HIV/AIDS vulnerability.

Although Soldan et al, (2007) argue that people involved in transactional sex in Mangochi are more likely to use condoms; such generalisation could be flawed as their study focused on male businessmen. Condom use among men is socially acceptable and hence such social norms can influence males' condom use (CSR 1997; Munthali et al, 2004; Chimbiri 2002; 2007). However, as condom use or even the suggestion to use it by females is associated with prostitution in Malawi, condom use among female businesswomen is more likely to be problematic (Chimbiri 2002; 2007). Thus, social identities associated with condom use were more likely to hinder businesswomen from adopting safe sex practices even if they were aware of the threat their unsafe sexual practices could cause. My findings therefore add a layer of complexity to current understandings of transactional sex (Nzyako et al, 1997; Nyanzi et al, 2001; Hunter 2002; Lerclerc-Madlala 2003a; Hallman 2004). They also add a new dimension in the analysis of the intersections between gendered social identities,

economy and sexuality that can contribute to unmarried adolescents' vulnerability to SRH problems.

Overall, structural gender asymmetry can disempower adolescents in their SRH promotion initiatives through the influences of gender-based norms surrounding sexual behaviours and gender-based differential in bargaining power which all could make adolescents more vulnerable to SRH problems. Gender role stereotypes hinder communities and government in their roles to provide social support and services as well as advocate for policies/programmes that can eliminate or reduce gender inequality that can disempower adolescents in their SRH promotion efforts. Moreover, the study results imply that as gender focuses on unequal power between males and females (Connell 1995; Morrell 2001), training of sexual health promoters that focuses solely on education and biological approaches rather than considering the sexual culture that could shape health workers' responsibility as cultural change agents may not have a positive impact on ASRH promotion in Malawi.

7.1.4 *Stigma: Discrediting Social Identities and Discrimination*

Stigma is a common form of overt social control of behaviour or maintaining social identities in many societies (Arboleda-Florez 2002; Rankin et al, 2005a; 2005b; Dlamini et al., 2007; Holzemer et al, 2007). Goffman (1963) defines stigma as an attribute or behaviour that is deeply discrediting within a particular society. However, the level of discrediting is social context specific (Stafford and Scott 1986; Crocker et al, 1998; Stacey 2004; Watkins and Jacoby 2007). Hence, Harvey (2001:175) describes stigma as '*a deviation from the attributes considered normal and acceptable by society*' while Alonzo and Reynolds (1995:304) describes stigma as '*a construction of deviation from some ideal or expectation*'. These definitions imply that stigmatised individual or behaviour bears a socially deviant attribute that defines the individual's social identities as flawed or spoiled. This label carries a connotation of weakness of character in the individual as defined by the social norms (Jones et al, 1984; Arbodela-Florez 2002; Rankin et al, 2005a); as Alonzo and Reynolds (1995) also describe stigma - "*a powerful discrediting and tainting social label that radically changes the way individuals view themselves and are viewed as persons*" (p.304).

As in some health conditions like tuberculosis and HIV/AIDS (Gilmore and Somerville 1997), premarital sex and hence SRH service use by unmarried adolescents is highly stigmatised and stigma is a major impediment to tackling SRH issues among this group in Malawi. Part of the cultural model of stigma in Malawi related to sexuality defines premarital sex practices as a deviant behaviour as unmarried adolescents are supposed to practise celibacy even though some traditions reinforce premarital sex (Hickey 1997; Kornifield and Namate 1997; Stewarts et al, 1998; Munthali et al, 2004). Stigma associated with premarital sex is usually based on cultural or religious morality which defines cultural conventions about what is socially and culturally acceptable in the society (Kleinman 1988; Byamugisha 2000; Ham 2004).

Due of the social conventions of morality, unmarried adolescents involved in sex are prejudiced, discounted and discredited (Reidpath et al., 2005a; 2005b). Stigma associated with premarital sex and use of SRH services leads to discrimination that originate from the adolescents' internalised response and/or the public response to the stigmatised individual or behaviour. Discrimination may take various forms: self, direct and structural discrimination (Gilmore and Somerville 1997; Link et al, 1997; Fife and Wright 2000; Siyam'kela Project 2003; Holzemer et al, 2007); all of which have implications for health promotion (Bell 1997; Link and Phelan 2001; Mason et al, 2001; Duffy 2005; Corrigan et al, 2005; Major and O'Brien 2005). The findings in this study also demonstrate that the deviance labels attached to unmarried adolescents' sexual behaviours have social and psychological effects (Weiss et al, 1992; Siyam'kela 2003) which can affect ASRH promotion. The effects of stigma include self, social/structural and institutional discrimination.

Self discrimination is associated with internal or felt stigma resulting from perceived loss of social identity (Jillings and Alexus 1991). Internal stigma is defined as a person's perceived view of stigma – emic view of stigma (Weiss et al, 1992). In ASRH promotion, internal stigma may be triggered by the adolescents' suspicion of what people think about them because of their sexual behaviours (Holzemer et al, 2007). Because of the importance of social identities in maintaining social reputation, internal stigma arouses fear of suspicion, loss of self-worth/self-respect and self discrimination in stigmatised individuals.

Fear of suspicion leads to silence, secrecy and denial among the stigmatised individuals due to concerns about disappointing others in the society (Black and Miles 2002) or resultant reactions from the society (Rankin et al, 2005a). Because of the effects of suspicion, some adolescents avoid to access appropriate SRH services or even adopting other behaviours (Webb 1997; Jackson 2002). Several examples were also cited during interviews where many unmarried adolescents avoided getting condom from hospitals for fear that they would be suspected of being sexually active by the society.

While fear of suspicion has a negative effect on ASRH promotion (Rankin et al., 2005a; Jackson 2002), it also encourages some adolescents to adopt self-protective behaviours as reflected in the in-depth interview results - "*I don't have a boy-friend because people who will see us together will think we have sexual intercourse*" (Female Adolescent 7, 15 years, Intervention Area 2) (see also Burkholder et al, 1999; Boer and Emons 2004). By protecting their social reputation, adolescents also protect themselves from SRH problems. This finding is not unique to Malawi as other studies have also documented that suspicion associated with having multiple sexual partners as being equated to prostitution encourages people to have one sexual partner (Bishop et al, 1991; Lew-Ting and Hsu 2002; Boer and Emons 2004) and this might reduce the risk of STI/HIV transmission.

However, this protective role of the fear of suspicion may be suppressed by some ambiguous culture. For instance, because some societies consider having multiple partners as a badge of social achievement among males, this protective role of fear of suspicion can only work if there are no norms that encourage the risky behaviours (CSR 1997; Munthali et al, 2004).

Besides, some stigmatised adolescents may develop coping strategies to protect their loss of reputation (Lazarus and Folkman 1984). The coping mechanisms may include denial (represented by statements like "*HIV/AIDS is for old people not young ones. My boy-friend can't have it, he is not old yet- Female Adolescent 5, 16 years, Intervention Area 3*); self-condemnation (represented by statements like "*If one has HIV what else can s/he do? S/he is dead already and is just waiting for time – Male Adolescent 3, 18 years, Non-intervention Area 4*); or construal or re-interpretation of their behaviours or the resultant

effects of their behaviours. For instance, while being aware of the cause of HIV/AIDS, some adolescents tend to associate the conditions with witchcraft. Such coping strategies can make adolescents unlikely to seek any SRH services or may seek healthcare from traditional healers which may not be effective. Similar observations were also reported in Zaire (Schoepf 1988) and Uganda (Kaleeba et al., 1991) where some men who had HIV/AIDS were involved in unprotected sexual behaviours without fear of re-infection due to frustration, denial, anger or self-condemnation. In this way, fear of suspicion and its associated coping strategies can discourage adolescents to adopt safe sex behaviours (Phelan, et al, 1998; Wahl 1999).

Internal stigma also leads to loss of self-worth or self-respect in stigmatised adolescents (Rankin et al, 2005a; Holzemer et al, 2007). Self-worth/self-respect enables adolescents to value themselves and to have confidence in their ability to fulfil their aspirations (ibid.). However, because stigma compromises self-worth or self-respect by inducing shame and other self-denigrating feelings within adolescents, stigma reduces the unmarried adolescents' agency to take SRH promoting actions (Rankin et al., 2005a). My findings cohered with this. Moreover, as loss of self-worth goes with lowered self-esteem, this also reduces adolescents' levels of adherence to the adopted safe sexual behaviours as they see no value associated with the adopted behaviours (Fife and Wright 2000)

> I sometimes ask my boyfriend to use condoms. Sometimes, I just feel it is unnecessary. I have got a baby already, so why should I bother about pregnancy prevention. […] Preserving the girl-hood status is what matters; after having baby, what are you trying to preserve? (Female Adolescent, 18 years, a school drop-out due to pregnancy, Intervention Area 3).

The effects of loss of self-worth can also be compounded by health workers who tend to undermine the self-esteem of young girls who have babies and yet visit hospitals for contraceptives - "*When I went to the hospital to collect contraceptives, the nurse laughed and asked me why I wanted contraceptive since I failed to continue with my education already because of pregnancy. These remarks make me feel never to return to the clinic*" (Female Adolescent, 18 years, a school drop-out due to pregnancy, Intervention Area 3). This means that unless the health sector is supportive of adolescents who feel self-worthless, effects of stigma will continue to hinder ASRH promotion efforts.

Internal stigma also leads to self-discrimination among adolescents due to their perceived feelings of negativity about their cultural images as a result of their deviation from socially expected behaviours (Corrigan and Watson 2002; Markowitz 2005; Rankin et al, 2005b; Holzemer et al, 2007; Dlamini et al, 2007). Due to self-discrimination, unmarried adolescents disassociate themselves from other people or institutions that could help to empower them through provision of SRH services or social skills development. Besides, other adolescents tend to distance themselves from the stigmatised behaviours even when they are helpful in SRH promotion. Examples were cited in the study whereby some unmarried adolescents reported to have avoided condom use because condoms are associated with sexual immorality. This stereotype of behaviours which has a negative connotation on adolescent's reputation could hinder unmarried adolescents from adopting safe sex measures (Biernat and Dovidio 2000).

Moreover, due to ambiguous culture, non-stigmatisation of unprotected sex (no condom use) within some societies; unprotected sex is considered a norm although such sex has health risks (Boer and Emons 2004) and most adolescents are aware of such health risks (ORC and Macro ORC 2001). This normalisation of risky behaviours however undermines adolescents' agency to adopt safe sexual behaviours because they feel that their 'unsafe' sexual practices are socially accepted. It can also undermine the community's role of counseling adolescents to use safe sex as 'no-condom sex' is considered normal. In this way, ambiguities associated with stigmatisation disempower adolescents and communities from undertaking ASRH promotion activities (Burkholder et al, 1999).

Social discrimination associated with received and associated stigma also hinders ASRH promotion. Received stigma includes all types of stigmatising behaviours from the social environment towards unmarried adolescents' sexual behaviours as experienced by the adolescents themselves or others (Weiss et al, 1992; Holzemer et al, 2007). Associated stigma on the other hand includes the stigma that other people receive due to their association with unmarried adolescents involved in sexual activity or using SRH services in the society (ibid.). These types of stigma lead to direct and structural discrimination. Direct discrimination occurs at a person-to-person level where other people's activities devalue, reject, exclude or blame the stigmatised individual (Jillings and Alexus 1991). Structural

discrimination occurs at a community or institutional level where the social contexts enforce stigma without person-to-person actions (ibid.).

Due to received stigma, mainly triggered by disclosure of one's sex practices, stigmatised adolescents avoid seeking SRH care due to fear of disclosure (Weiss et al, 1992; Holzemer et al, 2007). As the stigmatised adolescents are often seen as "*not quite human*", or "*substandard*" (Goffman 1963:5); they are discriminated, rejected, neglected or pestered by the society (Link and Phelan 2001; Ottati et al, 2005; Reidpath et al, 2005a; 2005b). Due to these public reactions, stigmatised adolescents avoid disclosing their behaviours and hence have difficulties in accessing health care (Newman et al, 2002; Vara-Diaz et al, 2005) and other community-based social services like resource centres that can empower them for SRH promotion (Samers 1998; Kai and Crosland 2001).

Similarly, associated stigma, usually triggered by continued association with the stigmatised individual or behaviour, reduces social cohesion which is important in health promotion (WHO 1986; Seeley et al., 1993a; UNAIDS 2003). Such stigma discourages the communities or health workers from promoting SRH among unmarried adolescents (Holzemer et al, 2007). Thus, associated stigma reinforces attitudes and social structures that can make people not to support unmarried adolescents in their SRH promotion initiatives. In this way, associated or received stigma generates stressful environments that can compromise communities' health promotion initiatives (Talashek et al, 2004; Rankin et al, 2005a; Kohi et al, 2006; Li et al, 2006; Dlamini et al, 2007; Naidoo et al, 2007) because people associated with the stigmatised individual or behaviour are viewed as deviants and immoral in Malawi (Chirwa and Kudzala 2001; NAC 2003). Similar observations were also reported in Botswana where stigma reduced community members' willingness to provide care to people with a stigmatised condition, HIV/AIDS (Letamo 2003). Thus, associated stigma undermines social cohesion which is essential in ASRH promotion (Seeley et al., 1993a).

Besides, the associated and received stigma's effects on community cohesion, they also lead to institutional discrimination which can be intentional or unintentional (Brown et al, 2003; Corrigan, et al, 2004). Intentional institutional discrimination occurs when an institution implements policies that can reduce opportunities for adolescents to access SRH

services. Unintentional discrimination could result from decisions or activities health facilities or health workers perform which are not based on any written policies but can limit the SRH rights of adolescents in unintentional ways (ibid.). Both intentional and unintentional institutional stigma makes health workers or health institutions restrict access of SRH services to unmarried adolescents (see also Li et al, 2006). This is evident with the case of Catholic health facilities which do not promote modern contraceptives (see also Nowska 1996), health facilities provide poor quality services as evidenced by short consultation time for counseling and SRH education in the current study (Tables 6.4 and 6.5) and staff's judgemental attitudes towards adolescents. This finding also concurs with other studies that showed that stigma negatively impacts on the quality of ASRH services provided to young people (Jillings and Alexus 1991; Chesney and Smith 1999; Lee et al, 2002; Duffy 2004). These restrictions and health workers behaviours are a result of symbolic attitudes which derive from the expression of denial about premarital sex as deviant behaviour in the society (Hickey 1997; Herek and Capitanio 1998). However, the poor quality of SRH services can make adolescents not to be adequately empowered with knowledge and skills required for them to make informed SRH choices and take preventive actions.

Additionally, the health workers' judgemental attitudes can discourage unmarried adolescents to seek care from hospitals (Newman et al, 2002; Letamo 2003; Duffy 2005; Reidpath et al, 2005a; 2005b; Varas-Diaz et al, 2005; Lieber et al, 2006. In this way, institutional stigma directly or indirectly encourages unhealthy sex practices among unmarried adolescents that might put them and their partners at risk of SRH problems (Duffy 2004; Kleinman 1988; Aujoulat et al 2002).

Similarly, associated stigma can discourage legislators or policy makers from supporting legislation or budgetary support of health services seen to promote socially unacceptable behaviours. Thus, fear of associated stigma can compromise political environment that can be conducive for the promotion of ASRH because lack of political support can undermine the health sector's capacity to provide services that can promote their SRH (Rankin et al., 2005a).

While this study concurs with other studies as shown above, it disagrees with others. For instance, while Letamo's (2003) reported that health workers with relatives with stigmatised SRH conditions are unlikely to stigmatise other clients with SRH problems, my findings demonstrate that health workers tend to stigmatise unmarried adolescents who use SRH services regardless of their children's SRH experiences

> Many young people in this area complain of my mother [a nurse] at the hospital. My mother shouts at girls who come to get contraceptives. Some say she also beats pregnant girls who come for delivery (Female adolescent 6, 18 years, a school-drop-out [due to pregnancy] daughter of a health worker, Intervention Area 3).

Crocker et al, (1998) and Major and O'Brien (2005) also argue that health workers' behaviours are generally related to their cultural background which stigmatises any behaviour socially unacceptable in order to maintain their social identities. Thus, health workers stigmatise and act in a prejudicial and discriminatory fashion towards unmarried adolescents' sexual behaviours.

Furthermore, although other studies argue that stigmatisation is lower in populations with accurate knowledge on SRH issues (Letamo 2003; Boer and Emons 2004) and among the more educated people (Kalichman and Simbayi 2004; Lau et al, 2005), the findings here suggest that stigmatisation is not related to accurate SRH information or level of education but is rather rooted in the social consciousness which define social morality (Freire 1973; 1998b; 1998b; Mustakova-Possardt 1998). This is evident by increased stigmatisation of premarital sexuality by health workers who have both higher education and increased knowledge about SRH issues (see also Chirwa and Kudzala 2001; Holzemer et al, 2007). Therefore, this study adds to knowledge and further provides an understanding of the underlying processes that influence stigmatisation by health workers.

Although stigma is used as a form of social control against disapproved social behaviours in many societies (Cohen 1985; Kahan 1997; Link and Phelan 2001; Blume 2002), the findings in the research show that stigmatisation of premarital sexual behaviours in Malawi is ambiguous and hence can hinder ASRH promotion. For instance, while premarital sexuality is associated with a spoiled identity in most societies, the same societies promote it as a *rite de passage* to adulthood. Besides, while premarital sexual activity is considered as immorality, celibacy is seen to be unnatural, inhumane or sexually abnormal in the same

societies (CSR 1997; Hickey 1997; Kornifield and Namate 1997; Munthali et al, 2004; Kaler 2004).

Moreover, stigmatisation of premarital sexual behaviours is gendered (Bunting 1996; Vlassoff et al, 2000) and this also contributes to cultural ambiguity. For example, while girls with a larger number of male sexual partners are viewed as prostitutes, a name that connotes a spoiled behaviour, boys with multiple female sexual partners are accorded a high status as social achievers, a behaviour that symbolises masculinity; a concept that raises social status (Hickey 1997; CSR 1997; Munthali et al, 2004). This ambiguous stigmatisation system can however be a source of confusion to adolescents' sexual behaviours as boys and girls are socialised into different and parallel norms within one society and yet they mix in their pursuit of sexual relationships (Duncan and Smith 2002). The ambiguities in the norms can confuse adolescents' choices of the social identity they have to emulate because each norm might have a significant value and meaning which adolescents would like to adhere (Turner 1981). The ambiguity in the stigmatisation can also affect ASRH promotion initiatives as social norms powerfully influence the day-to-day perceptions and behaviours of adolescents and other people in the society (Parr et al, 2004).

Besides, because the degree to which stigma can act as social control of behaviour differs from one person to another depending on the benefits associated with the stigmatised behaviour to the adolescents (Holzemer and Uys 2004), this means that stigma on its own cannot therefore be effective as health promotion measure. For instance, while stigma associated with having multiple sexual partners can help to discourage multiple sexual partnerships which can increase STI and HIV risks (UNFPA 2003), such stigma may not persuade girls who have multiple sexual partners for financial or material gains for their living. This finding implies that while stigma can be used as a social control of behaviour, it may not be effective in some people due to variations in motivating factors of adolescent sexual behaviours. Therefore, YFRHS should always understand adolescents' motivations for their sexual practices and probably consider audience segmentation and multisectoral collaborations when designing ASRH promotion in order to address the various determinants of unmarried adolescents' sexual behaviours and motivations. Thus, stigma is

detrimental to ASRH promotion as it undermines individual, community and health facility's capacity to undertake ASRH promotion initiative.

Overall, ambiguous normative culture, stigma and structural gender asymmetry disempower adolescents, communities and health workers in ways that can affect ASRH promotion. These social and cultural norms mediate the decisions, actions and behaviours of people in the society. Ambiguous culture, stigma and gender asymmetry have therefore implications for personal development, community actions, supportive environments and public health policy (WHO 1986a; 1986b) which can affect personal agency, social support and the role of health facilities in ASRH promotion. As such, facility-based YFRHS that could conscientise individuals' and community's social consciousness and transform social moral values affecting ARH can potentially contribute to ASRH promotion. The following section therefore examines the capacity of facility-based YFRHS to address the above determinants of adolescent sexual behaviours in culturally-sensitive societies of Malawi.

7.2 *YFRHS and Tackling Social Identities: Strengths and Limitations*

The study reveals that for facility-based YFRHS to effectively promote SRH among unmarried adolescents in Malawi, these facilities must be able to address social identity-related norms that influence the adoption of unsafe sex practices. The YFRHS programme should be able to empower adolescents, communities and health workers to challenge or resist the influence of social norms that increase vulnerability to SRH problems. YFRHS should also be able to create an enabling environment in which adolescents can have self-care, communities provide social support, health workers can provide effective health care to young people and people offer each other support in solving and managing collective health actions in culturally conservative society (WHO 1986a; Kickbusch 1996).

In line with the above prerequisites for ASRH promotion, this section examines the capacity of facility-based YFRHS to promote ASRH with specific reference to empowerment, use of biomedical approaches and the capacity of health workers to promote ASRH in a culturally-conservative society.

7.2.1 *YFRHS and Empowerment*

According to the Ottawa Charter for Health Promotion (WHO 1986), empowerment is central to all health promotion efforts. Empowerment should be facilitated at individual and community level in order to promote individual and collective initiatives for health promotion (ibid.). Individual empowerment is defined as the extent to which individuals feel they can control events in their own lives. Community empowerment on the other hand is concerned with modifying the social structure to reallocate power between groups so that community members can collectively control events affecting their lives (Sue 1981). This can include changing or renegotiating the social norms that influence adolescent sexual behaviours. Apart from the individual and community empowerment, health facilities which are central to health promotion in YFRHS need to be empowered to initiate and facilitate individual and community empowerment (WHO 1986a).

Evidence from the study however shows that facility-based YFRHS policies in Malawi appear not to be sufficiently able to empower the adolescents, communities and health facilities for ASRH in a culturally-conservative society. Health promotion in YFRHS policies for instance is largely based on behaviour change and communication (BCC) models premised on the cognitive assumptions where SRH education, life skills development and increased access to SRH services are used to mobilise adolescents and communities for ASRH promotion (NAPS 1999; NYCOM 2001; BRIDGE 2004). However, most BCC theories of behaviour change have no capacity to address the generic processes underlying social norms-related determinants of health. For instance, the commonly used models in Malawi including health belief model (HBM), theory of reasoned action and AIDS Risk Reduction Model (Bajos et al, 1997) focus on the individual as a foundation for personal behaviour rather than targeting the underlying basis for the meanings, perceptions and reasoning associated with cognitive processes. That is, interventions that could address the social processes that influence the values and meanings ascribed to their perceptions, rationality and reasoning could affect cognitive outcomes that can promote SRH among young people.

Conversely, BCC-oriented individual empowerment concentrates on interventions designed to increase individual independence and self-efficacy in SRH actions but no attempt is

made to address deeper social norms affecting adolescent sexual behaviours (Riger 1993). For instance, the HBM is based on the premise that perceptions of personal threats are a necessary precursor to taking preventive action (Kalichman 1998), and yet perceptions themselves are acquired through social interactions (Kirscht and Joseph 1989; Tones 1991; Kalichman 1998).

Similarly, rationality based theories of risk assume that an individual's behaviours are rooted in their rationality of what is healthy and harmful (Douglas 1992; Rhodes 1995). However, it is argued that what one thinks is also learnt through interaction with the social environment (Hirst and Wolley 1982). Rhodes (1995:128) also emphasises "*individual rationality is context and situation dependent*".

Likewise, while the theory of reasoned action views behaviour change as a function of the intention which is determined by a person's attitudes, beliefs and expected values (Fishbein et al, 1994), Fishbein et al, (1994) acknowledge that intentions are a product of social norms influencing the reasoning of an individual

> Subjective norms are viewed as a function of normative beliefs that specific referents (that is, certain individuals or groups) think one should or should not perform the behaviour and one's motivation to comply with those referents (p.63).

While theories such as those related to social learning are based on the "premise that behaviours, environmental influences, and beliefs are highly interactive and dependent" (Kalichman 1998:42), the strategies used in the processes such as modelling cannot change the social norms unless the critical consciousness of the role model is changed so that they can also influence other people's critical orientation (Freire 2000).

From these arguments on the role of social interaction in influencing people's cognitive processes, it may be seen that it is unlikely that BCC-oriented health interventions can change people's health behaviours if social norms are the basis of the health behaviours. Health promotion interventions informed by these theories miss the point as an individual may feel empowered but may only be lulled into false consciousness as this approach downplays the situational and structural factors informing and influencing adolescents'

decisions and actions (Riger 1993). Thus, empowerment focusing on the individual alone fails to address critical issues of power and powerlessness at community and national levels. Such findings are not unique to Malawi as other reports have shown failures associated with using approaches which lack conscientisation-oriented empowerment to promote health (United Nations 1995c; United Nations 2003; WHO 2007) probably due to the strategies' failure to transform social norms. This means that there is a need to have a model shift from BCC models of behaviour change to social transformation-oriented models in health promotion.

Furthermore, the training policy in Malawi fails to adequately empower health workers to become cultural change agents. The training guidelines for YFRHS providers define empowerment in terms of provision of SRH education, life skills development and community participation without a focus on a conscientisation process for communities and, importantly, for health workers (NYCOM 2001). This limits the capacity of YFRHS providers to become cultural change agents in the society. Instead, empowerment in YFRHS interventions involves directing adolescents on what to do rather than helping them to have options from which they could make their choices of actions. In this case, YFRHS implementation in Malawi is in contradiction with participatory empowerment that can increase people's critical consciousness (Freire 2000). Such preparation of health workers that does not enable them to conscientise communities is more likely to allow the communities to shape the views and attitudes that would keep other people of the society powerless in controlling their health (ibid.) due to the strong influence of social norms that promote their social identities (Turner 1981).

Moreover as health sector policies regarding SRH promotion among unmarried adolescents conflict with the traditional approach to ARH promotion, the tension created disempowers adolescents, communities and health workers. For instance, while the health sector uses the "abstinence, be faithful to one partner and condom use" (ABC) strategy, the traditional "*abstinence, abstinence, and more abstinence*" (AAA) (Figure 6.1) only strategy works against the western ideologies of SRH promotion. This traditional approach denies the opportunity to empower adolescents in other alternative health promotion measures including condom use and use of other modern SRH commodities that can promote their

SRH. Thus, the moral (AAA) approach fails to empower adolescents sufficiently because it does not provide services that would meet the diverse SRH needs of different adolescents. Wuest and Stern (1991) also argue that empowerment means that people have choices and freedom to take actions that would increase their control. Therefore, the moral approach, by emphasising abstinence only, limits available choices of alternative methods that could be used to protect their SRH.

Because the ABC strategy is resisted by communities as a result of their cultural or religious beliefs (Byamugisha 2000; Baier and Wright 2001; Montfort undated), there is a lack of community support for ARH interventions that are perceived to be at odds with social norms. An example was cited that religious institutions work against the government to abandon an explicit campaign that promotes condom use among unmarried adolescents because condom use is socially unacceptable due to its association with promotion of premarital sex. This finding is not unique, as Zabin and Kiragu (1998) also noted, ASRH interventions that were contrary to the community views and went beyond SRH education emphasising abstinence counselling to the provision of condoms to unmarried adolescents was considered to be at odds with social norms in Kenya and this resulted in resistance to such initiatives by the communities. Due to such attitudes, communities are less likely to encourage unmarried adolescents to use condoms to promote their SRH. These community reactions are therefore more likely to disempower unmarried adolescents for SRH promotion due to their social norms influencing their behaviours. Health policies that are aimed at empowerment for health promotion should therefore be able to conscientise and demystify issues by raising the collective critical consciousness of the population if ARH goals are to be achieved (Gomm 1993; Mustakova-Possardt 1998).

Furthermore, health care delivery in Malawi is defined in terms of caring for other people. In the light of this, according to Labonte (1989), the way YFRHS are provided in Malawi identifies them as a service instead of a resource for community empowerment and this disempowers adolescents and communities. Labonte (1989) defines a service as "*something controlled by the provider*" and a resource as "*something controlled by the person to whom it is provided*" (p.25). This view of YFRHS in Malawi therefore causes health workers to assume an expert role and clients a recipient role. This attitude forces or encourages health workers to define problems for the communities (Labonte 1989). This is

facilitated by the health professionals' socialisation through systems of health professional education and hierarchical management structures which emphasises the importance of expertise in health promotion (Chavessa 1991). This expert-novice model used during provider-client interactions in YFRHS puts health workers in control positions and undermines the act of empowerment, especially if the providers have no participatory empowerment skills (Gruber and Tricket 1987; Gomm 1993). It also tends to underestimate the communities' capacities to deal with health issues. Health promoters generally think communities do not understand health issues, consider them as passive recipients of health care and hence deny the communities a lead role in their health promotion initiatives; which contravenes the Ottawa Charter of Health promotion (WHO 1986).

However, according the Ottawa Charter for Health promotion, it is clear that in order to empower people for health promotion, YFRHS providers need to learn to see themselves as resources for the community. Moreover, they need to see themselves as equal partners with the recipients of care so as to empower the clients and communities to participate in activities that can promote their health (WHO 1986a; 1986b). According to Labonte (1989), participatory health care can assist health promoters to change from being "*architects and managers of social change"* and communities from being "*the community recipients of our own professional largesse*" (p.24) and become partners in ARH promotion. While shifting of roles as embraced in participatory health care could pose a challenge for health workers, proper training of the health workers that re-socialise them to partnership working in health promotion could be effective in changing the health workers' roles as Stewart (1990) commented "*moving from superior provider to equal partner requires basic modification of roles and resocialisation or reprofessionalisation*" (p.24). As such, training of health workers needs to be reconsidered in order to change ways in which health workers' behaviours disempower others in ARH promotion initiatives (Labonte 1989).

Thus, health professionals need to redefine their roles and reposition themselves as a *resources* and not *'service'* providers so as to encourage individuals and communities to perceive that they can solve their own problems and can influence anything that can affect their life (Freire 1972; Matheson and Matheson 2008), and that they can have great impact on their own health. According to Matheson and Matheson (2008), "*this is a necessary step*

towards developing a critical consciousness of the social environment- or conscientisation- and gaining the power for people to take charge of one's destiny and hence transform it, instead of remaining passive and entirely subject to the force of circumstances" (p.32). In this case therefore, YFRHS need to ensure that health promoters have knowledge and skills to be enablers and facilitators of participatory empowerment for health rather than taking a directive role in health promotion (Labonte 1989). They should also be advocates on the clients' behalf in the pursuit of policies and programmes that can conscientise the communities (Mustakova-Possardt 1998). The above discussion thus, indicates the necessity for redefining the YFRHS policy to promote conscientisation-oriented health care system. This is essential if empowerment for ASRH of communities and health workers is to be achieved.

As there are no YFRHS policies in Malawi that strengthen the community actions through conscientisation, community actions towards ASRH promotion is still weak. Thus, unlike the UNICEF's Baby Friendly Hospital Initiative's (BFHI) whose success was based on its design and implementation structure that focused on ten steps that included community empowerment besides empowerment of the health facilities (UNICEF/WHO 1990; 1991; UNICEF undated), the participation in YFRHS in Malawi was information giving rather than active participation as reflected in the client exit interview results (see also Chambers 1994). Thus, while the BFHI engaged community structures (see Cooke and Kothari 2001) in the design of activities that were used to promote exclusive breastfeeding (WHO/UNICEF 1990; UNICEF 1992; 1999; Armstrong 1999), communities in YFRHS are basically informed of the programme activities so that they can support them. This however contravenes the principle of empowerment as it requires that clients should participate actively in defining and prioritizing their problems and in decision-making and problem solving rather than just discussing with them already laid-out programmes (Kalnins et al, 1992; Putnam 1993a; 1993b; Gibson 1993; Rissel 1994). In a way, participation as it is implemented in YFRHS in Malawi to a certain extent disempowers the communities to lead and control initiatives towards ASRH promotion in their societies.

Due to the deficiencies in participation strategies, community action towards ASRH is weak contravening the Ottawa Charter for Health Promotion's (WHO 1986a) proposition.

Community actions include ambiguous SRH messages and counselling passed on to young people as there were no policies to shape the wider environment to promote ASRH (Simnett 1995). For instance, formal institutions like schools (UNESCO/MIE/UNFPA 1998) and traditional institutions such as families and religious groups continue to socialise young people based on the cultural systems such as gender roles and other traditions that undermine individual and community empowerment towards SRH promotion (Munthali et al, 2004; CRH 2005; Chege 2005; Chimbiri 2002; 2007). The ambiguity in the socialisation process however confuses the empowerment process of adolescents as they are exposed to different social identities on which they are supposed to model their lives. This implies that unless YFRHS have the capacity to conscientise people to challenge or resist the social norms that limit or restrict their empowerment, it will be difficult to achieve empowerment for ASRH promotion (Kiefer 1984; Freire 1993a; 1993b; Hawe and Shield 2000).

Moreover, as some of the western ideologies of empowering adolescents are at odds with social norms in some Malawian societies, this could lead to tensions in the implementation of community empowerment activities. For instance, the view to empower some groups especially the young people conflicts with the traditional view. There is no social provision in the Malawian culture that gives young people control of any part of their lives. Thus, while the current empowerment programmes consider that each person has a right to control their health (Malawi Equity Network undated; WHO 1986; United Nations 2003; UNAIDS 2003b; WHO 2005), these rights are seen to conflict with traditional views of the rights of children in some Malawian societies. Socially, parents have roles and responsibilities to make decisions about the health care and health decision-making for their children. Children are seen as being incompetent and incapable of representing themselves and this disqualifies them from making their own health-related decisions (James and Prout 1990; Kalnins et al, 1992; Hagquist and Starrin 1997). Similar observations were also made by Wight (1994) who noted that traditional views hold that parents are the natural protectors of their children hence independent rights for young people are seen as unnecessary. Such views can be a source of tensions that can affect community empowerment for ASRH promotion. However, due to this traditional view which denies young people's rights which has not been challenged due to lack of community conscientisation, parents and communities do not promote empowerment

programmes for young people, let alone encourage or empower their children to control their own sexual health. Other writers agree that young people might be incapable of making well-informed health decisions of their own (Hegar 1989; Gibson 1993; Hagquist and Starrin 1997) probably due to their lack of cognitive development.

However, as adolescent the age-bracket is wide; the level of development of adolescents varies. Some may be cognitively well developed and experienced while others may not. As such, audience segmentation; whereby empowerment is facilitated relevant to age, sexual experience or educational status can be an effective approach to address the diverse needs of adolescents with different attributes and SRH needs. Although audience segmentation is inherent in the BCC model (see NAC and MoH 2003), it does not encourage participants to reflect on their own factors that affect their SRH. Instead, SRH information is imparted on them based on their ages, for instance. By contrast, audience segmentation using Frierean health promotion approach can help participants to realise the factors affecting their SRH after reflection on their lives and social environments (Friere 1998b). Thus, segmentation in Friere can facilitate evolution of the social consciousness regarding the SRH determinants. Furthermore, though Friere worked with largely homogeneous groups, each group needed to be critically aware of the nature of their relationship with the others (Friere 1973). In sexual health however, heterogeneous groups can be used in order to reflect on issues of sexuality, often gendered, that affect SRH (Ng et al., 2000). This audience segmentation should commence in all socialisation institutions and health facilities to ensure that adolescents receive appropriate services to facilitate the development of appropriate knowledge, social skills, self-efficacy and autonomy necessary to control their own sexual health (Tayside Region Education Department 1993; Kalichman et al, 1996; Sex Education Forum 1997a; 1997b). Gibson (1993) also emphasised that "*practitioners [need to] provide clients with information and decision-making power consistent with their age and capabilities* (p.390). Thus, audience segmentation in Frierean approach to health promotion can provide a *rational action model* because participants are involved in identifying factors that affect their health and also plan the ways to address those factors.

Moreover, although community gate-keepers are involved and hence could facilitate the creation of supportive environments for individual and community empowerment, the impact of their involvement could only be possible if they are conscientised in ASRH

promotion (Freire 2000). Otherwise, without conscientisation, they are likely to maintain and reinforce the social norms that hinder empowerment for ASRH. Without conscientisation, community leaders can hardly accept changes that may affect their authority in the society (Freire 2000). Moreover, without conscientisation, such community-driven approaches may fail to acknowledge and challenge the political realities of power and this may lead to inclusion of interventions that do not meet the needs of marginalised groups such as orphaned adolescents (De Kadt 1982; Dasgupta and Beard 2007).

Moreover, the notion of social group or social identity can also hinder the capacity of YFRHS to effectively empower community for ASRH promotion. According to Tajfel (1978), the notion of group identity means that individuals see themselves primarily as representatives of the salient social identity that leads to "depersonalisation" of individual to represent a "collective self" (p.63). Other studies also concur with these findings reflected by the fact that regardless of the benefits the individual autonomy could bring to their lives, some people reinforce cultural practices that oppress their own or other people's rights and freedoms while at the same time sanction any person who questions such norms (Hickey 1997; Caldwell et al, 1998; Chimbiri 2002; 2007). Because of this attitude, interventions that aim to empower communities to teach their children to control their SRH are likely to be unwelcome as that would contravene the group norms. Thus, social identity enhances adherence to social norms even when the consequences of embracing the identity will affect their health or hinder their health promoting role (Turner 1982).

Social identities also have emotional significance and values attached to them that can discourage people (adolescents, health workers and adults) who are members of the traditional group from undertaking activities that can promote ASRH (Tajfel 1981). Because of affiliation to traditional group, people tend to bring moral understanding to their daily activities regardless of socio-economic or educational status (Malawi Strategic Framework 1999). The moral understanding often makes them not to question their behaviours or the consequences of their actions (Freire 1973; Mustakova-Possardt 1998); some of which may be risky to SRH. The moral understanding also makes people to seek and establish morally responsible relationships with these realities; while others adjust to unjust social realities (e.g. girls having no control over their SRH issues regardless of

having more knowledge than their male partners) and make the best use of it. All these influence of social identities disempower communities from carrying out actions that can promote ASRH. From this analysis, it is clear that social identities play a great role in community empowerment and activating personal agency. Therefore, YFRHS that can raise group members' critical consciousness towards the role of social identities and the social world realities can address this cause of disempowerment in the society (Hagquist and Starrin 1997).

In this case therefore, the YFRHS community empowerment policies that model after UNICEF's BFHI programme (UNICEF/WHO 1990; 1991) but using the conscietisation model (Freire 1973) has a potential to facilitate social transformation that can enhance the creation of environment conducive for ASRH promotion. This is also evident from the findings that show that community empowerment that leads to community activities that are seen to be at odds with social norms are associated with adoption of safe sex practices among unmarried adolescents (see Tables 6.6, 6.7 and section 6.3). The effectiveness of conscietisation models in health promotion in Malawi has also been documented in PMTCT programmes where mentor breastfeeding mothers with HIV facilitate other HIV mothers with newborns to have a positive life during their breastfeeding period of their babies (Mothers to Mothers International undated; Thom[19] 2008, personal communication).

Despite the realisation that adolescent sexual behaviours are embedded in a complex way in the social environments in which adolescents live (Sidell 2002), YFRHS workers in Malawi are not well prepared to empower adolescents and communities to challenge or resist the influences of the social norms. Currently, YFRHS workers use approaches such as SRH education and life skills development as means to empower adolescents (NYCoM 2001; NAPS 1999; MIE 2000). These approaches however cannot address the underlying processes behind the effects of social norms. As such, the influence of social norms continues to impact on people's behaviours towards ARH promotion. This was evident in that despite BCC campaigns to gender equality, gender inequality is still acceptable and reinforced in most Malawian societies (Kaler 2004; Chimbiri 2002; 2007). This clearly

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shows that the current YFRHS programme lacks the capacity to transform the authentic moral authority influencing the sexual behaviours (Mustakova-Possart 2003).

In conclusion, YFRHS in Malawi do not have the capacity to effectively empower adolescents and communities to take a lead role in health promotion activities. Lack of conscientisation-oriented theories in the facility-based YFRHS hinders YFRH workers (as discussed in the next section) from empowering adolescents and communities as embraced in the Ottawa Charter of Health Promotion (WHO 1986a). The study therefore elucidates the challenge societies with strong social sexual norms pose to the empowerment for ASRH promotion.

7.2.2 *Role of Health Workers in ASRH: Health Promoters or Moral Guardians?*

Health workers are at the centre of health promotion implementation in Malawi. However, their role in ARH promotion is affected by their dual social identities. An exploration of the cultural context and individual personality indicates that health workers have public and private images that influence their health promotion roles. The public image represents the public health professional role while the private image represents the personal life influenced and informed by the one's cultural and social norms (Elshtain 1981). These public and private images affect their health promotion efforts due to the conflicting interests between them that create tensions when carrying out their roles (Relman 1983; 1984). Due to influence of culture and the importance attached to its adherence, health workers in Malawi usually portray private images in their daily activities (Chirwa and Kudzala 2001).

Social reputation is important and valued in Malawi. Because of this, health workers ensure carefully demarcated boundaries exist between professional and social roles when providing SRH services so that they maintain their reputation in the society (Chirwa and Kudzala 2001). For instance, while the health sector had policies that attempt to empower adolescents for SRH promotion, most health workers do not carry out the SRH promotion activities due to constraints imposed by the social norms in the society. Similar findings were reported in another study in Malawi that showed that 58% of health providers in five health facilities including two major hospitals refused to provide SRH services to youth due to cultural or religious reasons (Chirwa and Kudzala 2001). In some cases, health workers

refuse to be deployed in the YFRHS section or to provide SRH services to unmarried adolescents or continue to ask for consent to use SRH services although such policies were abolished in the health sector in Malawi. All these were signs of disapproval of unmarried adolescents' sexual activity or SRH service use and indeed, social norms pose a challenge to the reorientation of health services aimed to promote ARH particularly for unmarried adolescents (WHO 1986a).

Moreover, while quality of care is another aspect that can attract unmarried adolescents to use SRH services (United Nations 1995a; Senderowitz 1999; UNFPA 2003), social norms influence health workers to provide poor quality care. Evidence from the client exit interviews reveal that unlike with adults, health workers spend little time during consultation with adolescent clients (Table 6.5) while others were judgemental as a sign of disapproval to unmarried adolescents' sexual behaviours. Other health workers tend to moralise the working spaces as well as their health promotion actions. They tend not to warmly welcome young people as it is equated to approving premarital sex in the society (Rogoff 1990). Such attitudes which can negatively affect ASRH promotion due to cultural traditions have also been reported in other developing countries including Kenya and Uganda (Kaiser Family Foundation 1999; Horizons 2001). This leads to the provision of poor and inadequate SRH information which would not adequately empower adolescents to control their SRH (see Table 6.4).

Furthermore, while health promotion requires health workers to promote SRH rights, social and religious norms discourage most health workers from promoting SRH rights as that is contrary to the social norms (Weeks 1985; Kaleeba et al., 1991; Chimbiri 2002; Chege 2005). These attitudes are more likely to disempower adolescents in their pursuit for SRH as it heightens their anxiety when accessing SRH services besides fearing the consultation assessment questions which are embarrassingly personal and intrusive (Kaiser Family Foundation 1999). In this way, social norms encourage health workers not to fulfil the Ottawa Charter for Health Promotion pillar which requires the reorientation of health services to meet the SRH needs of unmarried adolescents (WHO 1986a).

Although, health workers are in good position to be advocates for ASRH promotion in the society (WHO 1986a), social identities affect their advocacy role in health promotion.

Their knowledge and community's trust on the health workers could enable them to effectively advocate for social change that can benefit ASRH (Aiello et al., 1990; Johnson and Baum 2001). However, most health workers tend to advocate ASRH services that could not stigmatise them (Hatchett et al., 2004; Dlamini et al, 2007; Holzmer et al, 2007). This means that other services such as modern contraceptive use including condom use which are stigmatised in most societies are not advocated for. Thus, unlike the BFHI which was strongly advocated at hospital and community level by health workers (UNICEF/WHO 1990; 1991), most health avoid advocating for YFRHS because of its association with promotion of premarital sex which is socially unacceptable in most societies.

Moreover, most health workers who also double as parents tend to support the social traditions despite their knowledge of SRH problems and their consequences among young people (See the case study of the health worker mother - page 213). Thus, instead of taking advantage of their SRH knowledge to be cultural change agents, they reinforce social values at the expense of effective health promotion (Trevarthen 1988). Such health workers' attitudes result in low support in terms of adolescent, community and resource mobilisation which are all important for effective ASRH promotion.

While the stigma can be blamed for the low level of advocacy for YFRHS, it can be argued that lack of conscientisation could be the main barrier to advocacy. This is evidenced by PMTCT Projects which also deal with highly stigmatised HIV/AIDS (Dlamini et al, 2007; Holzmer et al, 2007) but yet is advocated even among other community members probably due to community mobilisation approach that aims to change community's social consciousness about HIV/AIDS which has led to self-reflection and acceptance of the condition by individuals affected as well as the communities (Thom 2008, personal communication). This finding means that lack of effective approaches to prepare the health workers to become agents of cultural change makes them instead to become guardians of culture who reinforce moral values at the expense of health promotion values (Trevarthen 1988). Similar observations were made by van Loon and Wells (2003) who noted that in conservative societies where social norms are the basis for morality, health workers are more likely to be influenced by the moral framework and that can affect their health promotion role.

Although Relman (1983; 1984) argues that health sector policies can help to change the behaviour of health workers towards achieving health promotion goals, health workers in Malawi tend to replicate the social and cultural values and ideologies of the larger society despite that SRH policy stipulates otherwise (MoHP 2002). Examples were observed in SRH provision where despite having SRH rights (ibid.), some health workers in Malawi still ask the unmarried girls if they have parental consent in order for them to provide them with certain SRH services or are judgemental during service provision to unmarried adolescents and thus reflecting their social stand as regard SRH rights. This is not unique to Malawi as other studies have also reported similar observations (Goetz 1995; Macdonald et al, 1997). This evidence suggests that unless health workers' social identities are transformed; health facilities would be moral guardians' centres instead of being health promoting centres. This can disempower and discourage adolescents from accessing SRH services at the clinics (WHO 1986a). Therefore, YFRHS need to adopt an empowerment model that will conscientise health workers as well as prepare them to become facilitators of cultural change during service provision in the clinical and community settings.

7.2.3 *Biomedical Approaches and ASRH Promotion*

> 'She was bewitched and caught an illness similar to AIDS': AIDS and sexually transmitted infection causation beliefs in rural … (Mshana et al., 2006)

For long time, there has been a tendency to treat SRH problems like teenage pregnancies and STIs including HIV/AIDS as purely medical issues rather than behavioural issues (Whelan in Loon and Wells 2003). Though several scientific researchers frame sexual acts that can lead to such ASRH problems in a biological model and describe sexuality in biological perspectives that gives SRH appearance of moral neutrality (Furby and Marom 1990; Millstein and Igra 1995; Adams and Pigg 2005; Hendricks 2005), the findings in this study demonstrate that health initiatives that are limited to medical interventions including increased access to services are likely to have limited impact on SRH promotion. The qualitative results reveal the cultural aspect of sex practices in Malawi which has a strong influence on adolescent sexual behaviours. Examples of cultural perspectives that influence sexual behaviours include norms that promote masculinities, initiation and cultural cleansing rituals. However, because the YFRHS use a biomedical approach to SRH service provision that merely address problems of service accessibility rather than combat the

social determinants of ASRH including the influence of social identities in adolescent sexual behaviours, YFRHS' capacity to effectively promote ASRH in Malawi is undermined. This coheres with Kaler (2004) who argues that though biomedical approaches emphasise scientific knowledge, some SRH problems in the communities are explained from inevitability perspective theories. According to inevitability perspective, SRH problems are considered as part of life which cannot be prevented (ibid.). Socially, most people in rural Malawi believe some SRH issues are unpreventable. For instance, people believe that contracting HIV/AIDS is unpreventable as it is God's punishment for sins while pregnancy is God's gift. That is, people have a pre-ordained destiny for their lives (Letamo 2003). In most societies, sexual behaviour is associated with 'nature'; a strong, primordial, often irrational force that cannot be resisted (Mtika 2001; Kaler 2004).
This finding is not unique to Malawi. As inevitability perspective theory assumes that it is only supernatural power that can prevent any SRH problem that a person is destined to encounter, use of supernatural power as means to promote sexual health is not uncommon in Africa (Zachariah et al., 2002; Heald 2002; Letamo 2003; Mshana et al., 2006). In most cases, people believe that some health conditions like HIV/AIDS and pregnancy are unpreventable as their occurrence is under the influence of God. Thus, people believe that one cannot do anything to prevent their occurrence. Such beliefs however disempower adolescents and communities from using or promoting use of health facilities for SRH services and instead prefer traditional health care (Byamugisha 2000).

Moreover, though being a faithful member of religious institutions is advocated by most churches as armour to protect oneself against the devil's power which influences unmarried adolescents to engage in the 'prohibited' sexual activity (Montfort Press undated; Byamugisha 2000), some reports show that premarital sex and ASRH problems are widespread among church-going adolescents (Williams et al., undated; Short and Onyacha 1998; Ham 2004). However, because of religious norms, churches/mosques do not take action to promote ASRH. This means that health promotion that is solely based on biomedical approach and does not transform the socio-cultural norms that influence adolescent sexual behaviours can hardly reduce SRH problems among unmarried adolescents in societies where culture shape people's behaviours. Such behaviours can put

church-going adolescents at risk of SRH problems. Ayanga (cited in Byamugisha 2000:3) also narrated

> Religion is one societal institution whose influence pervades all the other institutions. It provides support for cultural norms and can be a means through which change can be effected. …But it can hinder or block social changes. The lives of religious adherents can be affected either positively or negatively by religion...

Moreover, as the use of the biomedical approach such as condoms as a way to prevent early pregnancies and STIs including HIV/AIDS appears 'unnatural', coming from a realm outside the normal course of life (Mtika 2001; Kaler 2004), the use of such biomedical approaches in ARH promotion are unlikely to be promoted by the religious community. This means that unless YFRHS transform people's consciousness on the causation and prevention of SRH problems, the biomedical approach alone cannot be effective in ARH promotion. YFRHS also need to raise adolescents' consciousness of the realities of the social world so that they can behave in ways that can promote their SRH.

The emphasis on YFRHS that fosters dependency on health care and medicalisation of SRH problems could also not address the non-medical determinants of SRH problems. However, biomedical approach's inadequate attention to socio-cultural environment and emphasis on biomedical approaches undermines the understanding of the determinants of adolescent sexual health in Malawi as Kunitz 1990:106) asserted

> Many health problems in both rich and poor countries are still best explained by weakly sufficient causes, or risk factors. Understanding their incidence, prevalence, and distribution, as well as their prevention and treatment, may require intimate understanding of particular people and settings. This demands a different kind of science, one based upon local knowledge, social organisation, cultural beliefs and values, and patterns of behaviour, rather than simply universal knowledge of the behaviour of viruses and GNP per capita.

Thus, unless YFRHS in Malawi are reoriented to consider the social determinants of adolescent sexual practices, it is unlikely that it will be effective in ASRH promotion as it fails to take account of the unique circumstances influencing ASRH practices in different societies (Hayes and Willms 1990).

Although biomedical approaches neglect the impact of the social environment on ASRH, three theories of psychological development postulate that parents have direct influence on adolescents' identity formation which can influence adolescent sexual behaviours-

Attachment theory (Bowlby 1969; 1988), separation-individuation process (Blos 1967; 1979; Kroger 1998) and theory on individuation in family (Grotevant and Cooper 1985; 1986a; 1986b). These theories state that parents support processes such as exploration and commitment[20] as well as the individual development process by providing a warm, secure and autonomy-supportive environment at home. These parents' behaviours influence adolescent sexual behaviour development (Beyers and Goossens 2008). Thus, identity formation in adolescence is the balance between self and other people in the adolescent's environment (Kroeger 2004). The results of this study are consistent with these theories as it has revealed that adolescents who had interactions with their parents on sexual issues were more likely to adopt safe sex practices (Table 6.7).

Also, as most adolescents prefer parents as the primary source of SRH education (Table 6.6) and that they spend most of their lives with their parents (Seiffge-Krenke 2006), this means the biomedical model leaves out the role of parents and communities in adolescent sexual behaviour. This critical omission is likely to affect adolescents' SRH. My finding is consistent with that of other writers who also describe the health care system's deficiency as the main factor leading to self-care deficit in ASRH promotion among people in the community (Harris and Stern 1986; Wuest and Stern 1991). In this way therefore, biomedically-oriented YFRHS cannot effectively promote ASRH among unmarried adolescents as it is likely to fail to empower the adolescents and communities to exert control over the social determinants of SRH (Campbell and Jovchelovitch 2000).

Moreover, as there are variations between biomedical and cultural models of health and health practices in Malawi (see also Asplund and Britton 1990; Aarons and Beeching 1991; Nishida and Sakamoto 1992; van Delden et al, 1993; Ryan et al, 1993; Koch et al, 1994), there are likely to be differences in the constructions of SRH problems as well as the ways to address them. These variations are likely to affect health seeking practices of adolescents.

They are also likely to cause tensions in the implementation of biomedical-oriented care in the societies that have their own constructions of SRH. This is evident in the conflict

[20] Exploration means encouraging young people to explore the social world. Commitment means explaining to them why it is important to make clear and sound choices concerning relationships (Beyers and Goossens 2008).

between the health sector's ABC model and the traditionalists' 'abstinence, abstinence and more abstinence' (AAA) model (Figure 6.1) for ASRH promotion. Another example is the tension between the health sector's provision of SRH education and the traditionalists' resistance to provide SRH education to young people arguing that sex education would promote unsafe sex practices although there is no evidence to that effect (Roye 2001; Graham et al, 2002; Raine et al, 2005). Such tensions can affect the empowerment of adolescents for SRH promotion.

Also, as cultural values and beliefs about health are trusted by the indigenous people in Malawi (Phiri 1997), some communities seeking to buttress their moral worth resist any health care that does not recognise cultural norms (Blaxter 1997; Zachariah et al, 2002; Imogie et al, 2002; Kusimba et al., 2003; Mills et al., 2005b). This can result in community resistance to promote some of the activities that can promote ASRH. As such, integrating the cultural aspect of health care could promote ARH promotion as that could attract the local people to use services because they would feel their cultural views are part of the health care system (Castro and Marchand-Lucas 2000; Mills et al, 2005a). This finding coheres with that of other writers who also argue that health interventions that leave out the cultural perspectives may not be welcomed in culturally-sensitive communities (Adams and Pigg 2005; Stimson and Donoghoe 1996; Rival et al., 1998).

While the introduction of YFRHS in Malawi represents the reorientation of health services to respond to adolescents' SRH needs as embraced in the Ottawa Charter for Health Promotion Framework (WHO 1986a), the current YFRH approach fails to curb the determinants that disempower adolescents for SRH promotion. Although the framers of YFRHS at the ICPD emphasise a holistic approach that includes families' roles, promotion of gender equality and equity, empowerment of women and SRH rights in SRH (United Nations 1995a), there is need for Malawi YFRHS to adopt strategies that would address the social norms and identity-related influences because they strongly influence unmarried adolescent sexual behaviours. The failure to adapt the ICPD goals to suit the Malawi situation (in this case with specific emphasis on addressing the role of social identities in ASRH in Malawi) can hardly address the factors that disempower adolescents, communities and health workers to promote their ARH and that needless barriers to effective execution of YFRHS continue (Manderson and Whiteford 2000).

Overall, the discussion above shows that facility-based YFRHS in Malawi do not have the capacity to empower adolescents, communities and health workers to promote ASRH in culturally-conservative societies. The BCC–oriented models, the use of biomedical approaches in SRH service provision and the preparation of health workers contribute to the deficiency of YFRHS' capacity to empower adolescents, communities and health workers for ASRH promotion as enshrined in the Ottawa Charter for Health Promotion (WHO 1986a). This study therefore proposes the use of the Frierean conscientisation theory as the empowerment framework for YFRHS implementation within the Ottawa Charter for Health Promotion (ibid.) in Malawi in order to effectively address the social norms and identity-related processes underlying adolescent sexual behaviours and ASRH promotion. Also in their book, the Ford Foundation (2005:17) stated

> The world has begun to recognize that the HIV pandemic (*and other sexuality-related problems*[21]) cannot be confronted simply by applying a disease-based, biomedical, technological model of intervention; a new model must be applied that addresses sexuality, sexual rights and gender power relations.

The following section therefore discusses the applicability of the Frierean framework (Friere 1973) as the model to be used in ASRH promotion to facilitate the transformation of social-related factors influencing the adoption of risky sexual practices among unmarried adolescents in societies where culture is the main driver of behaviour.

7.3 ***Conscientisation and Empowerment: Transformative Approach in ASRH Promotion***

> The experience of families of children with persistent middle ear problems supports the notion that when families become empowered, they manage their own health more effectively. […] Questions are raised about the nature of empowerment and the changing role of the nurse (Wuest and Stern 1991:80).

Empowerment is at the centre of World Health Organisation's (1986a) Ottawa Charter for Health Promotion. However, a review of various programmes reveals that there are different strategies that have been used to empower adolescents, communities and health workers for ASRH promotion (Mati 1989; Campbell and Williams 1999; Kim et al., 2001; WHO 2007). Evidence of the impact of the empowerment strategies used in ASRH promotion has varied from one context to another (ibid.).

[21] Words in brackets are my own inclusion

Although most studies in sub-Sahara Africa show that access to SRH services has been associated with empowerment of young people to adopt safe sex practices (Kim et al, 2001; Kirby 2002a; 2002b; Obasi et al, 2003), the present study demonstrates that social and moral values related to social identities undermine unmarried adolescents' empowerment in the SRH promotion initiative. Social identities influence unmarried adolescents', communities' and health workers' agency for health promotion. Adolescent sex practices are a result of a process of collective negotiation by adolescents in social group settings and adolescents act in ways that do not contravene the identities of their social groups. Similar observations were reported elsewhere in Malawi (Helitzer-Allen 1994; CSR 1997; Munthali et al, 2004; Chimbiri 2002; 2007). Similarly, the influence of social identities on SRH service use is also documented in most developing countries (Nare et al., 1996; Mayhew 1996; Wolff et al, 2000; Oheneba-Sakyi and Takyi 1997; Dreze and Murthi 2001). These social norms and identity-related factors disempower adolescents, communities and health workers to promote ASRH in culturally-conservative societies (Turner 1982; Trevarthen 1988; Uba 1992; Dixon-Mueller 1993a; 1993b; Nare et al., 1996; Mayhew 1996).

The present study reveals that due to influence of social norms, health workers and communities carry out health promotion for unmarried adolescents in accordance with their expected social roles so as to maintain their status in the society. Because the social norms to a larger extent disapprove premarital sex and hence use of SRH services, health workers and communities are not supportive of unmarried adolescents' SRH promotion initiatives (see Chirwa and Kudzala 2001). Internally, social norms influence adolescents to allow others to control their health (e.g. gender roles and health care provider-recipient relationships). In this way, the present study confirms that social identities constrain people's autonomy in relation to their sexual lives and hence SRH promotion (Fekadu et al, 2001; Taffa et al, 2002). Thus, social norms present a challenge to health promotion as conceded in one of the policy statements in Malawi

> The challenge is to achieve reform of those cultural norms, values and practices which predispose Malawians to HIV infection (Malawi Strategic Framework 1999: Strategy 4.1).

Freire (1998a; 1998b) also commented that norms that influence social identities go hand in hand with disempowerment. Also, disempowered people view the power of the cultural and moral values and beliefs as virtually magical that needs to be followed without questioning (Freire 1973; Mustakova-Possadrt 2003). Due to these attitudes, health providers, SRH service users and other community members are therefore "*submerged in a situation in which they are not equipped to know and respond to the concrete realities of the world*" (Freire 1986:10). This situation makes people disempowered by social norms less likely to feel that they can take control over their health. As social and cultural values fuel ASRH problems, there is a need to effect a model shift from biomedical-oriented health promotion to one that would facilitate transformation of oppressive social/cultural norms (Hartweg 1990; Zrinyi and Zekanyne 2007; WHO 2007). Several researchers agree that health promotion interventions that do not reform cultural values may make ASRH interventions ineffective (Packard and Epstein 1991; Waterston 1997; Kalipeni et al, 2004; Mitchell et al, 2005; Kalipeni and Ghosh 2007). Ideally, this means that YFRHS should have the capacity to transform the way in which social identities and their associated recipes for living are collectively shaped in everyday life context for them to promote sexual health (Campbell 2000; Campbell and Jovchelovitch 2000).

Additionally, YFRHS settings should provide a social context within which adolescents and the community can collectively construct individual and collective identities that challenge the ways in which traditional cultural norms place adolescent health at risk (Campbell and Jovchelovitch 2000). Therefore, this thesis argues that the use of social identity-transformative approaches to ASRH promotion in culturally-sensitive society rather than the traditional BCC approaches will be effective in liberating the adolescents, health workers and communities from the social oppression that affect their health or health promotion roles (Blakey and Pullen 1991; Orme and Starkey 1999). Other studies also support the importance of challenging social structures in the promotion of health (Obasi et al, 2003; UNAIDS 2004; WHO 2007). Based on my findings and evidence from the literature, this study advocates the use of Freire's conscientisation theory to transform community's critical consciousness about social identities and how they can influence their health (Freire 1973). Hence, the next section discusses the notion of conscientisation-oriented health promotion.

7.3.1 ***Process of Conscientisation-Oriented Health Promotion***

Conscientisation is defined as the process of identifying and ultimately challenging the social and political structures that oppress disadvantaged groups in the society (Freire 1973; Edwards and Hulme 1992). Specifically, Edwards and Hulme (1992) describe conscientisation as the self but collectively reflected critical consciousness awareness which is "*... an initial step in the process of identifying and ultimately challenging the social and political structure that oppress them (i.e. disadvantaged)*" (p.24). Thus, conscientisation involves efforts to identify and address the underlying systematic forces of oppression (Friere 1973). Freire's conscientisation is a radical approach that prepares people to transform their social worlds including the social, emotional and moral values that disempower them in order to be able to control these factors (Freire 1973; Mustakova-Possardt 1998).

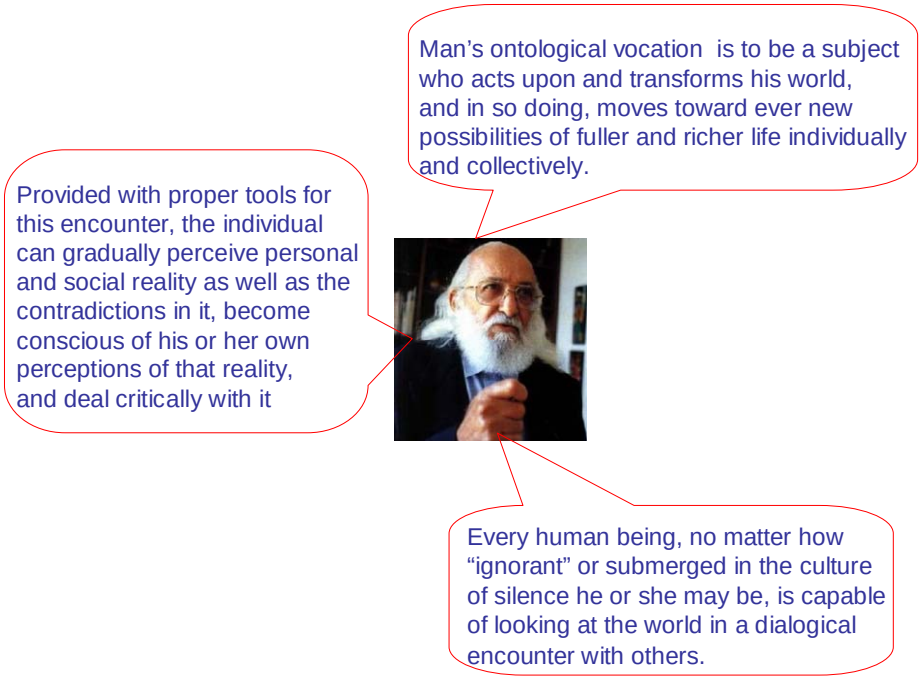
In health promotion, conscientisation can be described as the effort to enable people to become critically conscious about the social realities affecting their health (Freire 2000). This process can help people perceive factors limiting their ability to control their health and allow them to realise the opportunities they have for overcoming such oppression through community action (Edwards and Hulme 1992). Conscientisation can result from a combination of political education, social organisation and grassroots development (Freire 2000). Commenting on conscientisation, Sidell (2002) explains:

> Freire argued that human fulfilment can only be achieved when people are liberated from oppression. In order to be liberated they need to acquire a critical awareness of the world in which they live. *This conscientisation* (sic) is the process of change in consciousness where people gain the knowledge to make accurate and realistic awareness of their place in the world in relation to others. From that position of awareness they are enabled to act to transform their world (p. 61).

Thus, Freire outlined a theoretical framework for overcoming inequities by arming subordinate or oppressed groups with skills to reflect critically on prevailing social and political realities so that awareness and interests can evolve (Mayo 1995). This framework allows a socially informed understanding of oppressive relationships in the society which can affect ASRH. Such understanding can offer conceptions of the relationships between social identity, participative processes and power which can inform interventions to promote autonomous adolescents who are likely to carry out health promoting activity in

contexts where social identities are major determinants of health (Mumby 1997). In this way, conscientisation can provide tools for individuals and groups to emerge from an oppressive subculture to transform their social worlds and act in favour of promoting their health – see Friere's diagrammatic view (Figure 7:1) below.

Figure 7.1: *Freire's Process of Conscientisation*



Source: Freire 1998b: 14

Thus, the process of conscientisation or critical consciousness raising aims to enable people (adolescents, health workers, communities) to perceive social, political, cultural and economic oppression and to take action against the oppressive elements of the society (ibid.). According to Freire's model, five components are crucial to conscientisation-based empowerment: dialogue, conscientisation, praxis, transformation and critical consciousness (Freire 1976).

Dialogue is the essence of Freire's conscientisation model of empowerment (Cornwall and Jewkes 1995; Freire 2000). In health care, dialogue can be defined as the authentic exchange or discussion between health provider and client on real concrete awareness about social contexts influencing health. The social reality should be from the clients'

perspective. Praxis refers to reflective action or active reflection or work that people engage in that could transform their world (ibid.).

In Freire (1976), transformation is defined as a process of changing people with naïve consciousness of reality into people who can see the theory behind the reality of the social world. Social transformation implies the articulation of the traditional values that disempower people to carry out health promotion activity (Freire 1973; O'Brien 1999; Mustakova-Possardt 2003). However, transformation does not mean integrating people into the structure so that they can become part of the oppressed society. Instead, transformation connotes independence, status and integrity (Freire 1970; 1976). Transformation can also be the articulation of the traditional values that motivate people to adhere to their cultural values or the evolution of individual and community in the changing contexts in order to make sense of their social world, their own relatedness to it and increasing their responsibility towards challenging the existing knowledge (ibid.).

Lastly, Freire defines critical consciousness as "a process of moral awareness which propels people to disembed from their cultural, social, and political environment, and engage in a responsible critical moral dialogue with it, making active efforts to construct their own place in social reality and to develop internal consistency in their ways of being" (Freire 1973:13). This critical consciousness can lead to political organisation of the people who are affected (Freire 1976). Therefore, within a Freirian framework, an important goal of YFRHS should be to provide a context for the development of communities' and adolescents' collective and critical consciousness and re-negotiation of sexual and social identities in ways which are less damaging to ASRH. This can be done through three mechanisms.

- First, YFRHS should facilitate an understanding of the way in which social identities, constructed within the context of Malawian culture, undermine the likelihood of good SRH among unmarried adolescents;

- Second, YFRHS should develop and promote a context within which adolescents can collectively develop the belief and confidence in their power to resist dominant

social norms that affect their sexual health, that existing social norms can be changed and stimulate the creation of scenarios for alternative ways of being;

- Lastly, as the social identities are shaped and reinforced by the society in which adolescents live (Dahlgren and Whitehead 1991), YFRHS should also empower the communities and facilities to create enabling and supportive environments for ASRH as resistance to changes in social identities by societies and health facilities can be an obstacle to ASRH promotion.

Thus, YFRHS settings need to facilitate creation of environments in which there would be re-negotiation of collective identities in conjunction with the development of targeted groupings' confidence and ability to act on collective decisions in favour of health-enhancing behaviours (Moodley and Akinsooto 2003). This renegotiation of social identities is likely to lead to liberation from social oppression and hence to empowerment for health.

While the understandings of empowerment tend to focus on the emotional or motivational dimensions of empowerment which conceptualise it in terms of a subjective sense of confidence rather than the individuals' objective ability to act in the face of structural constraints (Wallerstein 1992; Tawil et al, 1995), Freire's definition of empowerment adds a more cognitive or intellectual dimension, focusing on people's intellectual ability to analyse the environmental circumstances that might affect their health (Freire 1993a; 1993b). This Freirean model has implications for the health system especially in the management and provision of health promotion services and preparation of health promoters if the health system is to be effective.

7.3.2 *Implications and Challenges of Frierean Approach for Health Promotion*

7.3.2.1 Management and Provision of Health Promotion Services

The health sector in Malawi uses a Primary Health Care (PHC) approach to ASRH promotion (NYCOM 2001). Although popular participation is used to empower the communities in the PHC strategy through which facility-based YFRHS is implemented, the approach lacks the capacity to change the social forces influencing health and health seeking practices (WHO 1978). The PHC's emphasis on eight components (ibid.) that

exclude community conscientisation cannot adequately empower people to transform the social norms that influence their health behaviours (Freire 2000). Thus, the health services lack a genuine sense of empowerment whereby health workers can enable adolescents and communities to "*reflect on the codified version of their 'reality' in a process of praxis*" (Mayo 1999:33). Instead, health services seem to create a scenario where adolescents and communities expect the health workers (as experts) to satisfy their health demands for them to be healthy (Matheson and Matheson 2008). The Freirean theory will however require the health workers to enable adolescents and communities to reflect on the social environment, identify the determinants of ASRH in their community and find resolutions to address the root cause of the problem (Freire 2000).

Moreover, though YFRHS incorporate components of the Ottawa Charter for Health Promotion (WHO 1986a) , the Jakarta Declaration on Health Promotion which promotes collaborations (WHO 1997), the Bangkok Charter for Health Promotion in a Globalised World (WHO 2005) and the health promoting hospital framework (WHO 1993; WHO 1991) which put empowerment at the centre of health promotion, lack of conscientisation and critical consciousness in the empowerment approach also means that the YFRHS in Malawi cannot transform the social norms in favour of ASRH promotion (Mustakova-Possardt 1998; Freire 2000). Furthermore, although the recent charters for health promotion promote advocacy that focuses on cooperation with other players in the form of health alliances (WHO 1993; 1997; 2005), such alliances cannot be effective to transform social norms due to lack of conscientisation empowerment approaches (ibid.). However, such alliances are likely to increase the channels and agents for service delivery (Fortmann et al, 1995; King 1998; WHO 2005).

Additionally, globalisation (WHO 2005) and collaborations (WHO 1997) could also facilitate mixture of cultures and alliances of institutions with different values and norms which can affect or confuse the social identities of the local people if there is no transformation and uniformity of the values. Thus, these collaborations and removal of geopolitical boundaries can complicate the sexual identities. Therefore, further development needs to be considered at the policy level to ensure that alliances and globalisation do not create social identity confusion or tensions that can lead to SRH problems in some societies. In this case, there is need for various partners to discuss, reflect

and develop shared values that can help to pull their ARH promotion initiatives in one direction (Gugushe 1996; Mustakova-Possardt 1998). This could imply a theoretical shift from the commonly used BCC models to Friere's conscientisation theory to inform values and principles of ARH alliances. This has implications for preparation of health workers, service organisation and resource allocation. The theoretical shift would also require donors who prescribe the health promotion strategies to change their approach to incorporate conscientisation-oriented theories in their funded programmes.

As evidenced from the study, ASRH promotion is not health-facility based; it goes beyond to communities. This means that policy also needs to emphasise not only the creating of a health promoting environment at the hospital level but also in the communities so that the living environments of adolescents offer alternative models for social identity development that could enhance their SRH. This could also alleviate the effects of lack of adequate resources because the fewer health workers can concentrate on other activities either at the hospital or community levels. Health promoters besides serving adolescents (through the provision of SRH education, counseling, life skills development as well as provision of other services like contraceptives including condoms in the community) should also act as facilitators in the conscientisation of the communities. Thus, they together should facilitate social change which will eventually create a supportive and enabling environment for ASRH promotion. In this case, the use of youth clubs, local health committees and other community resources to facilitate conscientisation can be helpful. Thus, wider community conscientisation can promote efficient provision of ASRH services in the face of limited health workers as more people in the community will be health promoters.

Apart from policy development, the use of the Freire model in health service provision should also involve change from health promotion approach that is outcome-centred to process-centredness (Wallerstein and Bernstein 1988). In this case, health service provision should not prescribe any acceptable result but rather only specify the approach to be adhered to. To achieve a process-centred approach, the provision of health services needs to be a three-phased process aiming at addressing the underlying structures influencing health: defining the health issues, dialogue/reflection, conscientisation and action phase (Gugushe 1996). However, these processes should be adolescent or community-led in order to promote empowerment (Labonte 1989; Friere 2000).

Furthermore, while the health provision service in Malawi is based on the health providers' expertise, Freire's model requires that health service provision should be participatory with client and providers as equals. In defining health issues to be solved, Freire demands that the problem should be defined from a client's perspective (Freire 2000). Thus, health promoters should let the client or community members identify and determine their priorities (Gugushe 1996). This approach would help the health promotion service address the real cause of health problem in the society rather than one based on outsider's view. Anecdotal observations in Malawi also noted that due to lack of client participation, many clients complain that health workers do not provide appropriate care as reflected in phrases like "*before I finished presenting my problem, the doctor had finished prescribing my treatment. […] That is why doctors miss out most of the health problems people present to them*" (Male Adolescent 2, 16 years, Intervention Area 1).

Moreover, while provision of health care in Malawi is based on biomedical model which stipulates strict health problem management guidelines to direct the course of action like flowcharts for a Syndromic Management Approach of STIs (MoHP and NAC 2003), the Freirean approach requires that there should be a dialogue or discussion between providers and clients on how they can explain and address the health problem (Freire 2000). Dialogue means that health facilities should provide opportunities to have a two-way discussion between providers and clients or community groups on the root causes of ASRH problems in the community. Gugushe (1996) also suggests that instead of basing the service provision on the fixed medical guidelines, this dialogue or reflective phase should facilitate identifying the social context and the many facets of the health problem. Gugushe further suggests that in order for health promoters to facilitate this phase, a five-step questioning strategy could be used which should ask clients to:

1. Define the SRH problem adolescents/communities feel and see
2. Explore the various facets influencing the ASRH situation/problem
3. Share their lived experiences of the ASRH problem and its determinants
4. Question and discuss why the ASRH problem exists
5. Develop action plans to address the ASRH problem

(Adapted from Gugushe 1996)

This approach can encourage social groups to have a common understanding of ARH problems and work together to develop a sense of personal and collective confidence and responsibility in their ability and roles to safeguard ASRH (Matheson and Matheson 2008). Participatory approaches can therefore enable adolescents and community members to renegotiate their social identities and these changes would represent a critical opportunity for health promotion interventions (Mc an Ghaill 1994).

From Freire's lens (Freire 1973), YFRHS provision in Malawi largely puts the health providers at the position where they are the main controllers of adolescents' health. The clients are viewed as passive recipients of care (see Labonte 1989). Freire (1998b) however argues that such a scenario where the more the clients act based on directives from health providers, the less likely they can develop the critical consciousness which can result from the interventions. Thus, while the biomedical approach uses the health workers as a 'service provider' to direct in the management of the clients, the Freirean model requires that the health workers should be 'resources' to facilitate or stimulate the clients to take action that can change the social context affecting ASRH or examine other options available to solve ASRH problems (Freire 2000). In other words, health workers should provide opportunities for participants' self-reflection as well as providing opportunities to groups of participants for joint planning, implementation and evaluation.

Furthermore, instead of making decisions for clients, health facilities should build cooperation between providers, adolescents and communities, foster unity on ASRH issues, develop effective communication and influence the process of political organisation to change policies and legislation that can adversely affect ASRH. Health promoters should also facilitate joint identification of social factors leading to ASRH problems and approaches to solve the problems through shared mission, vision and political organisation of the community (Sharma 2006). Such health promoters' roles could create supportive environments for ARH promotion because they can facilitate the addressing of the multiple bases of power in the society. The health sector's role as a 'resource' rather than a 'service provider' would help the health sector to gain influence in the cultural and social institutions, develop organisational capacity to address ASRH problems and exploit

tensions in social coalitions to create effective partnerships for ASRH promotion (Levy et al., 2003).

While conscientisation-oriented empowerment may initially appear unrealistic in the resource constrained Malawian context, several precedents of its application exist in Malawi. For instance, there is case in Malawi where the Kamuzu College of Nursing (KCN), through changing the perspective of the role of nurses in their curriculum, facilitated a change of the traditional view of nurses as doctors' 'spanner boys' or doctors' 'assistants' to one of 'independent practitioners' who work as partners with other professions in health promotion. Similar experiences were also noted in the Nankumba Community Safe Motherhood Project where community members who discouraged pregnant women from using health facilities but instead to use traditional birth attendants are now in the forefront of maternal care promotion by encouraging hospital delivery for pregnant mothers to prevent maternal mortality (CRH 2004; Siwande[22] 2008, personal communication).

An example of the use of conscientisation in the clinical setting was also available. Mothers to Mothers International - Malawi successfully uses trained breastfeeding mothers with HIV to mentor other HIV mothers who are pregnant or with newborns to positively accept their HIV status and adjust their life to prevent transmission of HIV to the babies (Mothers to Mothers undated; Thom 2008, personal communication). In all cases, processes of defining roles, identifying reinforcers/oppressors to actions, reflection and development of appropriate actions/solutions were used; and this might provide a blueprint for initiating a conscientisation-oriented health promotion. These cases exemplify how conscientisation can be used to change health promoters and communities to change their norms in a way that can promote health promotion.

In practice therefore, the following steps might be appropriate to initiate conscientisation-oriented health promotion programmes

1. Identify health workers who have or can develop their critical analysis skills and train them as change agents using Freirean approach

[22] Mary Siwande is the Project Coordinator for Nankumba Safe Motherhood Project, Malawi.

2. Select a small community where the health promoter would like to initiate conscientation-oriented health promotion initiative.
3. Bring together the community in a dynamic problem-posing interchange in which everyone learns from each other. At this level, the health promoter should take a facilitator's role to stimulate their reasoning. The conscientisation process should involve the community and adolescents.
4. Using a guided awareness-raising process (see table on page 253) , the facilitator should stimulate self and community reflections that move from discussion of ASRH problems to analysis of the problems' underlying social causes, and then to collective action to remove the causes. This stage should promote open discussions in order for people to share their lived experiences. To facilitate this, the health promoters could share their experiences including the bad or good experiences in their pursuit of ASRH promotion. This may involve a strategy for confronting the local, national or international power structures oppressing the community members' liberty to control the determinants of their health
5. Be aware that alternative priorities to ARH might be identified for action by the community members
6. The facilitator should ensure that the members of the initial group should be coached to be facilitators in their own community settings.
7. At the end of this process, evaluate the impact and using the lessons learnt; discuss the effects of the programme and then after a pause for reflection, develop an ASRH programme conscientisation model together with the community.
8. The programme can then be expanded to other parts of the community. However, as communities are different, different contexts should have their own models in order to ensure that the model responds to the needs of the local community.

While Freire's conscientisation framework has potential to transform the provision of ASRH services, there are challenges to using the theory in the effective promotion of ASRH in the Malawian setting.

While the approach can change the social critical consciousness of health workers in a way that can change them from being moral guardians, the health sector alone cannot create an enabling and supportive environment for ASRH promotion due to the diverse determinants

of adolescents' sexual risky taking practices. Because of the diversity of the determinants of ASRH- "*Poor health is the outcome of many forces beyond a young person's control, including the disease environment, family circumstances and personal vulnerability*" (Lloyd (2007:7), the health sector can only be able to address one or fewer factors that influence adolescent sexual practices but not all causes of individual vulnerability to SRH problems. As such, multisectoral collaborations will be important in ASRH promotion. Through multisectoral collaborations, various services may be provided by various sectors that may meet the needs of adolescents which can have direct or indirect impact on ASRH. Thus, with spread of institutions including schools, religious institutions, social welfare, entrepreneurship and many others in the society that interact with adolescents, synergies between health and other sectoral policies and programmes can provide an opportunity to have an approach that can address the diverse causes of poor ASRH.

Multisectoral approach can help to bring about programmatic and policy changes that can facilitate to address the various forces impacting on ASRH. This approach can increase adolescents' access to ASRH information and services through the establishments of multiple service delivery points by several sectors. These delivery points can bring health services and information closer to adolescents (Duflo et al., 2006).

Besides, integrated and intersectoral policies can also benefit ASRH directly or indirectly. Integrated policies can facilitate the creation of healthy public policy. The healthy public policy can manipulate the social policy environment to create a healthy social environment where adolescents, communities and health workers can undertake ASRH promotion interventions (WHO 1986a; 1986b). Sectoral policies which can promote investment in ASRH programmes can enhance healthy social environment which can promote ASRH. For instance, investment in improving school access by subsidizing the cost of education can result in increased school attendance during the teen years which could eventually elicite positive ASRH as acquisition of basic education is a critical building block for the development of health behaviours during adolescence (Marteleto et al., 2006; Duflo et al., 2006). Through education, adolescents could acquire knowledge and skills which can make them to have autonomy over their sexual health (Jejjebhoy 1995). Longer period of schooling also delays sexual debut, marriages, and could encourage adolescents to adopt safe sex practices to avoid childbearing (Jejjebhoy 1995; Mensch et al., 2006).

Besides, integrated and multisectoral approach can also influence some sectors to include ASRH in their policies even if health might not necessarily be a priority for the sectors (Epp 1996). Thus, by involving various sectors, more sectors' programmatic and policy change can become a part of the solution that can lead to healthy development of the adolescents which is a prerequisite for ARH as WHO (2001:7) stated

> Promoting healthy development in adolescents requires a shared vision with complementary action by different players, actions which are aimed at fulfilling their rights, and address their special needs.

The WHO (1986a) also asserted the need for a co-ordinated action by all development partners in order to achieve health promotion goals

> The prerequisites and prospects for health cannot be ensured by the health sector alone. More importantly, health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by non-governmental and voluntary organisations, by local authorities, by industries and by media (WHO 1986a:329)

Thus, multisectoral collaborations can create an enabling environment for ASRH promotion through collaborative and integrated programmes and policies that can have a profound effect on organisations, providers, communities and health outcomes (Terris 1980; McKinlay 1996).

However, multisectoral collaborations involve partners with different values, beliefs and ways of working, and also considering the influence of culture on social institutions' attitudes towards adolescent sexuality, conflicting interests may exist between the actors or sectors. This is evident religious and other traditional institutions were against the health sector's promotion of condom use among unmarried adolescents (see Chapter 5). As such, unless integrated approach go beyond multisectoral collaborations to involve change of perceptions and critical consciousness towards social reality in order to be able to facilitate conscientisation-oriented empowering social environment for ASRH promotion (Blount 1998), such collaborations may not achieve the goal of ASRH promotion in societies where collaborators have different views regarding adolescent sexuality and institutions' norms shape the sexual practices of people.

Because of the above challenge, multisectoral collaborations based on Friere's conscientisation model would yield social and health dividends that can promote ASRH in societies where culture shape people's attitudes and actions towards adolescent sexuality as well adolescents' sexual behaviours. The Friere's conscientisation processes could ensure that all stakeholders/sectors - education, community, health, social welfare and others facilitate the creation of conscientisation-empowering environment to enable young people to develop skills, cognition or cognitive abilities that can make them resist or challenge the influences of social forces. The conscientisation-oriented integrated approach would empower various actors who interact with adolescents to create a conscientisation-oriented enabling and supportive social environment in which adolescents can develop their critical consciousness (Mustakova-Possardt 1998; 2000; 2003). The changes in the broader features of the social system may be more effective vehicles for social change (McKinlay 1996; Dahlgren and Whitehead 1995; Barnet and Whiteside 2002). The critical consciousness can enable adolescents, health workers and communities to perceive, challenge and resist the social factors that limit their abilities to undertake SRH promoting activities targeting unmarried adolescents. Thus, the conscientisation-oriented health promotion initiatives in multisectoral collaborations should aim to empower each and every actor in the social environment to have the ability to influence the critical consciousness of adolescents. In other words, multisectoral and integrated approach based on conscientisation theory can improve the capacity of health system (i.e. all actors that affect health) to promote ARH.

Moreover, transforming the culture is not easy particularly that some of the health workers involved in the transformative health promotive will be custodians of the culture. Adherence to culture can pose problems even among health professionals or educators who are expected to offer guidance in terms of knowledge and attitudes (see Pathfinder International 1999; Chege 2007). Similarly, local people cannot easily change their norms as apparent opposition to their traditions may reduce their reputation in the society. In this case, Freire approach may need external facilitators[23] initially in order to motivate and persuade people to have a critical consciousness that will enable them to evaluate and reconsider their views on their socially-informed actions in ways that can promote ASRH.

[23] External facilitators are those who do not share culture with the people in the facility's catchment area

Alternatively, health promoters[24] who have been trained in conscientisation-oriented health promotion strategies supported by external facilitators should initially deliver SRH activities using Freire's model until when the local health promoters can independently manage the health promotion initiative.

In addition, the health promoters should have skills so that they should be able to facilitate participatory group discussions where communities can identify the sets of values and norms that affect adolescent sexual behaviours in the communities, discuss the various sets of values and norms with the aim of examining the effects and implications of such norms and can come up with plans of actions on how to deal with the values. Sharma (2006) also argues that the political and social processes inherent in the Freire's model can be challenged as being manipulative instead of liberating people from social oppression; which can affect their process of empowerment for health (Cooke and Kothari 2001; Hickey and Mohan 2004; Smith 2006). In this respect, YFRHS need to underline the necessity to approach community participation initiative with some care to ensure that community-led agenda are prioritised. Claims to participation in ARH promotion need to be more than just the wish to consult within a narrow policy framework (Cooke and Kothari 2001). In this case, the USAID's Community Health Partnerships (CHAPs) Project Model in Malawi in which communities took the leading role in MCH and SRH promotion (planning, implementation, monitoring and evaluation) can be used as a blueprint for participatory partnerships in ASRH promotion (Save the Children 2002). The use of well organised structures- village level (village committee), community level (community committee) and district level (district committee) ensured participation of community members in decision-making of the activities at various levels. The resolutions at each level were then discussed at the higher level which was comprised of the representatives from the lower levels. However, community members need to be trained in ARH and YFRHS so that they can be effective in their participation (NHS Scotland 2005).

Furthermore, because of the ambiguous normative culture existing within a society, some institutions may not opt for other values which other social groups have for fear that their social groups will be undermined. This was evident during the field work where it was

[24] That is, if the health promoters share the same culture with the people in the facility's catchment area.

noted that other tribes which were not Yaos refuse to undergo or associate themselves with initiation rites like *Jando* (male circumcision) or *Nsondo* (initiation for girls) for fear that they can be seen to respect the Yaos' cultural identities and thereby undermine their non-Yao identities. In this case, health promoters need to ensure that there is no dominance of one social group or tribe during the dialogue and action planning phases. Dominance of one tribe in the group discussion will lead to opposition from the non-participating groups. Health promoters hence need to ensure that all tribes or religious groups in the communities equally participate in drawing actions that could promote ASRH in the community.

Similarly, the use of Freirean approach in health service provision might not be unproblematic in Malawi. The approach requires health workers and clients to participate as equals in health promotion activities. This may be unrealistic due to first, differences in their capabilities which cause communities to lack confidence to discuss health issues freely and second, because the hierarchies in the health care system put health workers in a lead role in health care provision (Bhasin 1991). Communities perceive health workers as experts and hence avoid active participation in health promotion activities (ibid.).

Besides, the participatory approaches promoted in conscientisation theory may be resisted by some health promoters as that might threaten their positions especially if dialogue is used in policy formulation (Levy et al, 2003). As a result of the threat of participatory approaches on status quo, top-down approach could be favoured by those in power. A top-down approach may however further the oppressive structures that disempower local people to control their health (Freire 1970). In this case, it means YFRHS need to facilitate radical change in the perception and use of power in development work so that power structures should not be an obstacle to development. This means that there is a need for evolution in the health care system in order to remove the structural barriers to participatory health care provision approaches. This can be done through conscientisation where health workers can reflect on the impact of the current position in the health and the potential if their position is reconsidered for the betterment of health. This renegotiation of the health workers' role can facilitate the development of client-provider relationships of reciprocal trust based on equality (Arnold et al, 1991); which is a prerequisite for dialogue (Friere 2000). The YFRHS may also initiate power structure that uses participatory

approaches in decision-making. Where a power difference is an obstacle to participatory discussion, audience segmentation may be used initially with some independent facilitators to relay messages between different parties. Conscientisation should target all in the community, if not all then at least people who may cause resistance to social change.

Although multisectoral collaboration can encourage some non-health sectors to have some programmes and policies which can benefit ASRH, the approach can affect the participation of other stakeholders particularly donors who have special interests in the ASRH project goals. This can affect the funding of some SRH programmes as was the case with the Global Gang Rule which among other things withheld its support to UNFPA because the President Bush administration said that the funding supported coerced abortion (Medical News Today 2009). Similarly, because of the Catholic's no-condom approach, they do not participate in partnerships promoting condoms use while others may work against any efforts that are contrary to their values about premarital sexuality. Due to these actions, there may be lack of support (material or emotional) in the implementation of some ASRH initiatives. In this case, using of the Friere's model in ASRH promotion would require conscientisation of the stakeholders on issues of ASRH before embarking on partnerships.

Overall, the discussion shows that conscientisation-oriented health service provision has the potential to empower adolescents and communities for ASRH promotion if other barriers to its implementation are addressed. Thus, in order for those oppressed by the social norms to be able to promote ASRH, they need to be prepared to perceive the reality of the oppression not as a closed world from which they cannot exit but as a limiting situation which they can transform in favour of ASRH promotion (Freire 1973). The social environment also needs to be able to create a conscientisation-oriented enabling and supportive environment for adolescents so that they can capacity to resist or challenge the influences of social norms (Mustakova-Possardt 2003). Health workers also need to have the knowledge and skills necessary to implement conscientisation-informed health promotion activities.

7.3.2.2 Preparation of Health Promoters

As Malawi uses the PHC approach, various health providers involved in ASRH promotion exist. These include the health professionals, non-professional health workers like the health surveillance assistants (HSAs) and the community health volunteers. Although social norms are the main determinants of ASRH in Malawi (NAC 2003), most health workers are not adequately trained to address such social determinants of health. Generally, health workers are not trained to be cultural change agents (MoHP 1999). In Malawi health training is a political process which reproduces traditional practices, norms and values. For instance, it was observed that training of health workers to work in MCH prioritised female health workers at the health facilities.

Moreover, while ABC strategy is promoted in ASRH, an observation during one of the training session for YFRHS providers showed that trainers emphasise on abstinence as the appropriate way for SRH promotion among unmarried adolescents. Thus, dominant cultural ideologies embedded in the social norms and health care shape the training of health workers and shape their consciousness towards conformity and compliance with established practices in hegemonic institutions (Clare 1993).

Training of health workers in Malawi also prepares them to be 'service providers', acquiring all the control to decide and take action on behalf of the clients, rather than be a 'resource' to facilitate the clients' own decision-making process in their care (see Labonte 1989). Most literature also gives the impression that there is a fault in the educational process in the training of health workers that could affect their health promotion roles (Gross et al, 1987; Meleis and Prince 1988; Smith and Russell 1991).

From the Freirean perspective, however, the preparation of health promoters should have two aims: firstly, to conscientise them so that they can change from being moral guardians to cultural change agents because moral guardianship in health workers acts as a barrier to health promotion; and secondly, to equip them with skills necessary to facilitate conscientisation in their clients. This will have implications for curriculum, teaching and learning methods, and clinical setting organisation.

The health care training curriculum in Malawi is subsumed by medicine and operates under the influence of the biomedical model constructed within the positivist paradigm (see also McCall 1996; Roberts 2000). The biomedical model emphasises epidemiological determinants of health or Orem's self care model (see Mulanje College of Nursing 2000; NYCOM 2001) although it is acknowledged that culture is one of the major determinants of SRH in Malawi (NAC 2003). This makes the preparation of health workers inadequate in transforming cultural issues.

However, as cultural norms are at the centre of disempowerment for ASRH promotion, culturally-responsive health worker training informed by Freire's (1973) conscientisation needs to be a fundamental feature of YFRHS providers training (Gay and Kirkland 2003). The Freirean model requires that the training curriculum be influenced by theories that act as instruments for liberating the health promoters from the influence of their social and cultural background as well as imparting skills to health workers that will make them effective facilitators in conscientisation process (Freire 1972). The training would help health workers to empower the clients to perceive the socio-cultural factors that hinder them from achieving good health (ibid.). It would also help health workers to facilitate clients to unpack unequal distribution of power and privilege which affect health promotion and enable the clients to act upon the oppressive socio-cultural determinants (Gay and Kirkland 2003).

Other literature also supports the need for education which empowers health promoters to be engaged with the social world and foster change (Freire 2000; Leyshon 2002; Oladokum et al., 2007). In this case, instead of promoting rote learning of facts about ASRH, conscientisation-based curriculum should empower health workers to critically examine their social worlds in ways that can affect their health promotion roles. It should also prepare health workers to become cultural change agents. Thus, educational preparation that does not conscientise health workers cannot effectively promote health as health workers' role is not only defined by professional knowledge but also by social norms within their culture which can disempower them to carry out effective health promotion roles (Hugman 1991; Muskardt-Possardt 2003).

A conscientisation-oriented curriculum should also enable health workers to acquire knowledge and skills to effectively facilitate conscientisation in adolescents and communities they serve (Freire 2000). Health promoters need to acquire participatory facilitation skills. As such, the curriculum needs to emphasise on interactive teaching methods like case studies, role plays, sharing of experiences, debates and group discussion as means to provide SRH services/information to adolescents.

Participatory facilitation approaches can be helpful to conscientisation process of the society. They can stimulate critical analysis of reality, reflection, collective dialogue and reconstruction of reality and action in the course of dynamic social interactions or group discussions (Freire 1973). They can also facilitate reflection of health workers' own lives and that could also enable them to effectively enhance other people's social consciousness (Freire 2000). Such techniques would allow health promoters to gain an understanding of the underlying assumptions and pedagogical commitments that inform conscientisation-oriented health promotional strategies (Ironside 2003).

As the training of health professionals also requires clinical placement, the clinical settings may not have environments that can facilitate critical thinking. The clinical settings may reinforce the traditional practices that may contradict the theoretical knowledge the health promoters gain in their classroom (Clare 1993). This means that training of health workers needs also to radically change the clinical settings so that they can be conducive for acquisition of critical consciousness skills. This can initially be achieved by orienting the health workers in the provision of care using the Friere's conscientisation theory (Freire 2000) and be rolled out as new health workers who graduate from conscientisation-oriented curriculum are deployed in the clinical setting.

Although conscientisation-oriented training of health workers appears to have benefits in health promotion, there are some challenges to its implementation in Malawi. As health authorities in Malawi were trained following biomedical or disease-oriented curricula, they may not support implementation of Friere's conscientisation-oriented health promotion besides having problems to identify health trainers who can prepare health promoters to initiate the implementation of the Friere's conscientisation approach in the facilities and communities. This can make health trainers or health authorities to become moral

guardians when they are training the new health promoters or managing the health sector in order to main their social reputation in the society.

For culturally-responsive health workers training to succeed, trainers in training institutions need to be more self-conscious, reflective, critical and analytical of their actions so that they can also be change agents in the health care provision (Valli 1992; Zeichner and Liston 1996; Palmer 1998; Ladson-Billing 2001). According to Gay and Kirkland (2003) such skills can enhance the trainers' ability to facilitate in professional critical consciousness. Stronge (2002) also argues that such skills are required in trainers because training that would be based on the trainers' experiences, focusing on their own self-reflection, dialogue, praxis and critical consciousness of social norms and beliefs can facilitate self-reflection and critical consciousness development in the trainee health promoters.

However, there are opportunities in the health sector for revolution as a number of health professionals have been in the forefront of change in health care practice. Training institutions in Malawi has the capacity to initiate and lead such changes given the required orientation on Friere's model (refer to the KCN example mentioned earlier). In this case, Friere's conscientisation-oriented health promotion training needs to be health sector-wide and not only for the implementers in the field. This can facilitate sector-wide support for Friere's conscientisation health promotion strategies.

An additional feature is that most of the health workers training institutions are owned by religious institutions. Inevitably, to a greater extent their curriculum implementation is informed by their religious philosophies. Trainers and trained staff therefore can further the oppressive ideologies enshrined in the religious norms. These may include religious principles that disapprove the provision of modern contraceptives which can fail some training institutions to provide a good training environment for rights-based health service provision. This training environment would cause the health promotion trainees to acquire beliefs and attitudes that would negatively affect their health promotion roles because they would be socialised to moralise SRH services.

However, as training institutions are regulated by professional bodies such as the Nurses and Midwives Council of Malawi and the Medical Council of Malawi, their strong position and ability to set preconditions for training curricula and their implementation can help to reduce the problem. These institutions can stipulate conditions which health workers' training institutions must follow in order to be accredited.

The presence of powerful people who control the health sector policies but also favour biomedical approaches could be a barrier to implementation of transformative health promotion strategies. For instance, physicians who hold most of the managerial and policy making positions in the health sector may resist the implementation of conscientisation-oriented health training due to their biomedical background. Similarly, politicians who view health in terms of absence of disease can also be a challenge to appreciate the importance of transformative health care. This can result in lack of advocacy and resource allocation for such training activities.

However, as learnt in the NnN Project, advocacy in local/district government structures can help to make a breakthrough in influencing support of top level people who may be a barrier to ASRH promotion. In Mangochi for instance, the NnN's advocacy and politicking in district administrative meetings locally known as 'monthly district executive committee (DEC) meetings' helped the programme's agenda to reach top level managers. The DEC comprised of all politicians, legislators, traditional leaders and heads of government sectors in a district and these people could take the NnN agenda to other people or administrative structures including the parliament or other influential people who could influence policies or decision-making in various sectors. Alternatively, advocacy documents can be developed and submitted to influential leaders (see NAC undated). This can pave a way for ASRH agenda to reach the top level managers which local health workers cannot access to have discussion with them. In this case, health workers need to have good advocacy and politicking skills in order to convince other people to take up an issue that can benefit ASRH promotion.

Overall, use of Freire's conscientisation theories in health promotion can facilitate conscientisation of adolescents, communities and health workers for ASRH promotion.

Conscientisation would form the starting point from which adolescents and communities could collectively work towards redefining the social identities and norms in ways that might be less endangering to unmarried adolescents' sexual health (Freire 1993a; 1993b). It may also transform health workers from being moral guardians to cultural change agents in their health promotion roles. Thus, conscientisation can enhance a radical change of social norms and values that disempower adolescents, communities and health workers to carry out ASRH promotion roles in culturally-conservative societies. It can enable people to emerge from oppressive structures created and sustained by the social norms.

7.4 ***Conclusion and Recommendations***

7.4.1 *Conclusion*

This study aimed to examine the capacity of facility-based YFRHS to promote and facilitate the adoption of preventive measures for SRH problems among unmarried adolescents. Overall, the thesis concludes that the way facility-based YFRHS is implemented in Malawi is not effective in promoting the adoption of safe sex practices among unmarried adolescents. YFRHS fails to address the generic processes underlying the established patterns of social life because the services are not designed to conscientise or transform the social norms which strongly influence unmarried adolescent sex practices in culturally-conservative societies.

The study however provides new knowledge in the understanding of ASRH in Malawi.

- First, growing up in Malawi entails exposure to contradictory SRH messages influenced by traditional norms on appropriate social and sexual behaviours.
- Second, social factors associated with social identity such as gender, stigma and normative culture disempower adolescents, communities and health workers from undertaking SRH promotion activities for unmarried adolescents.
- Third, unsafe sexual practices among unmarried adolescents in Malawi are sustained not only by lack of access to SRH services, information and counseling but also by the social structures/norms that support such practices. Thus, the study offers a new understanding on the impact of ambiguous normative culture, stigma and gendered identities on the promotion of ASRH.

- Fourth, the study also offers a critical lens in understanding the importance of the intersection of gender, economy and social identities in increasing vulnerability to SRH problems.
- Fifth, the study illuminates the conflicts between the traditional models of ARH promotion and the western approaches of ASRH promotion which can derail health promotion in culturally-sensitive societies
- Sixth, the study adds to our understanding of the importance of raising critical consciousness within an empowerment model as the critical lens to be used in ASRH promotion in Malawi. Thus, health promoters' critical understanding of moral issues as they affect empowerment for ASRH promotion could help the health promoters determine the capacity health facilities need to have in order to promote ASRH in culturally-conservative societies. The study also offers a critical understanding of how Ottawa Charter of Health Promotion (WHO 1986a), YFRHS principles, social identities and Friere's empowerment models can be merged for use as a framework for implementing YFRHS in Malawi.
- Seventh, the study illuminates the importance of conscientisation facilitated within segmented audiences in order to address the diverse factors that affect the SRH of unmarried adolescents. Treating adolescents, health workers and community members as a homogenous group can mean that SRH interventions omit addressing some determinants of SRH that derive from groups other than adolescents. The notion of segmented audiences that is a feature of BCC approaches demonstrates the continuing need for promoters of YFRHS to be open to useful elements of the existing approach.
- Eighth, the study illuminates the importance of partnering with community health volunteers such as peer educators and YCBDAs as well as community-based SRH resources in the promotion of ARH.

All in all, the thesis concludes that unless facility-based YFRHS adopt a Freirean conscientisation-oriented empowerment approach (Freire 1973), health facilities will have no capacity to promote SRH among unmarried adolescents in societies where ambiguous social norms are central to adolescent sexual behaviours. Conscientisation therefore should form the starting point for the collective renegotiation of communities'

and adolescents' social identities and for the empowerment of adolescents to change their behaviour in line with such negotiated identities. YFRHS providers need to become cultural change agents to promote conscientisation in the community. Failing which, adolescents will continue to live and grow in an environment where traditional norms will perpetuate SRH problems among unmarried adolescents.

7.4.2 *Recommendations*

The study exposed weaknesses in the current design and implementation of the YFRHS in Malawi covering all aspects of policy, programme implementation and preparation of health workers. The following recommendations are therefore made in order to make YFRHS more effective in ASRH promotion.

A. Policy and Programme Level

- Ensure that programmes promote and advocate for heterosocialisation in all institutions (schools, health facilities, churches) in order to facilitate gender equality
- YFRHS programmes should focus on personal, community and professional critical consciousness development in order to improve their awareness, self-reflection and resolutions of the oppressive factors affecting ASRH promotion if ASRH goals are to be achieved in culturally-conservative societies. Johari Window can be used in raising awareness (Luft and Ingham 1955).

- Given the significance of social norms in ASRH, programmes should be conceptualised and designed to move from the current BCC models into a more social transformative programme framework using Friere's (1973) conscientisation theory in order to increase its capacity to transform social norms affecting adolescent sexual practices in culturally-conservative societies.

- ASRH programmes should always consider the socio-cultural context during designing in order to ensure that they address the sociocultural factors that disempower the adolescents, communities and health workers in ASRH promotion.

- Multisectoral collaborations should be promoted in order to facilitate the reduction of ambiguities in the socialisation of adolescents in various institutions because the partnerships would empower the institutions to give appropriate socialisation that can promote ASRH. Alliances can also enhance YFRHS to effectively address the diverse determinants of unsafe adolescent sexual behaviours. Mainstreaming of conscientisation-oriented policies (e.g. in education, social institutions) in adolescent development should also be initiated to empower the society to create enabling and supportive environments for critical consciousness development which can facilitate ARH promotion

- Community participation should be ensured in ASRH programme planning, designing and implementation in order to ensure that planned interventions have community support. Programmes should also consider adolescents and communities as partners in ASRH and not as recipients of their services.

- Considering the determinants of social contexts and the impact of community health volunteers on ASRH, the provision of YFRHS should go beyond the health facilities to the community. Programmes should strengthen activities of community volunteers in ASRH as they can act as cultural change agents and their acceptability by the society can enhance social transformation or be entry points for ASRH activities in societies with rigid cultural norms. Community members need to be oriented as facilitators of conscientisation process in ARH promotion to ensure a supportive environment for adolescents' critical consciousness development

- Given than adolescents are not a homogenous group and have different SRH needs at different stages of their lives, provision of SRH services to segmented audiences should be promoted to ensure that SRH needs of various adolescents are addressed.

- Policy makers should advocate the review of other policies or laws that disempower young people from controlling their SRH – for instance, the laws that give parents authority to consent to their daughters' marriage at 13 years of age. Instead, policy makers should reinforce policies that protect the rights of adolescents to access and

use SRH services including 'no discrimination, stigma or restrictive (e.g. consent requirements) policies' when adolescents visit clinics for services.

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- Policy makers should ensure adequate resource allocation for YFRHS in order to carry out ARH promotion based on Freirian approaches at community and health facility levels

B. Health Workers Training

- Health workers should be trained or prepared to become facilitators of health promotion rather than "providers" of promote health services

- Training curriculum of health workers needs to be reoriented in order to adopt conscientisation-oriented training of health care providers to enable them to become agents of cultural change (Chavessa 1991). The curriculum should focus on participatory and conscientisation-oriented empowerment approaches to health promotion. Trainers need to put social sciences subjects such as sociology and psychology of health at the centre of their health promotion training rather than focusing on biomedical courses only. Rote learning should be avoided.

- Operationalisation of health workers training in societies where culture is the main determinant of sexual behaviours should be contextually specific in order to prepare health workers to address the specific socio-cultural determinants of health in specific societies. Short courses or orientation of new staff on the culture specific to the facility's catchment area can be useful.

- There is need to re-orient all clinical health workers to Frierean conscientisation model in health care provision to ensure that the clinical setting is conducive for teaching and learning of health promotion students.

C. Areas for Further Research

- Considerable ethnographic research is needed to better understand social identity-related determinants of adolescent sexual risk-taking in Malawi. This can have a potential for alternative venues to provide ASRH education and services and ways in which YFRHS can be expanded or scaled up.

- There is need to assess the impact of conscientisation-oriented approaches in health promotion activities.

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Annexes

Annex 1: RESEARCH FIELDWORK PLAN AUGUST 2004 TO AUGUST 2005

ACTIVITIES	*T*		*I*		*M*	*E*								
	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
1. Travel to the field														
2. Meeting with the research collaborating institution staff														
3. Logistics														
▪ Recruitment and training of research assistants[25]														
▪ Organising and preparing the research sites														
▪ Photocopying questionnaires														
▪ Transport arrangement														
4. Data Collection														
▪ Interviews : Adolescents														
: Service providers														
: Clinic managers														
: Community														
▪ Participant observations														
▪ Service utilisation data														
▪ Survey														
▪ FGD														
5. Data Analysis														
▪ Interview data*														
▪ Observation data*														
▪ Questionnaires														
▪ Service utilisation data														
▪ FGD data														
6. Feedback to participating organisations/communities														
7. Meeting local research supervisor[26]														
8. Travel back to Edinburgh (College)														
9. Report to DoS														
9. Continue data analysis														

* Data analysis, comparative analysis, memoing, theoretical sampling and data collection occur simultaneously

[25] January training will be for research assistants to conduct FGD sessions; while February training is for interviewers for the survey

[26] Student will be constantly informing the research advisor on the progress of the fieldwork. Formal meetings will be arranged.

Annex 2: **Ethical Approval Documents**

Queen Margaret University College

EDINBURGH

Rob Coward
Assistant Registrar (Quality Enhancement)
Queen Margaret University College
Clerwood Terrace
Edinburgh
EH12 8TS

☎ 0131 317 3213
rcoward@qmuc.ac.uk

To whom it may concern

8 June 2004

Dear Sir/Madam

Dixon Bester Jimmy-Gama

This letter is to confirm that Dixon Bester Jimmy-Gama was granted ethical approval for his postgraduate research project titled *'Youth friendly reproductive health services and the adoption of STI, HIV/AIDS and pregnancy prevention strategies among unmarried adolescents in Malawi.'* This proposal was granted approval by the Director of QMUC's Institute of International Health and Development, Professor Alastair Ager, under the delegated authority of the University College's Research Ethics Committee on 21 December 2003.

I hope this confirmation is helpful. Please contact me using the above telephone number or email address if you require further information.

Yours sincerely

Rob Coward
Assistant Registrar (Quality Enhancement)

UNIVERSITY OF MALAWI

Principal

Prof. R.L. Broadhead, MBBS, FRCP, FRCPCH, DCH

Our Ref.:

Your Ref.: COMREC/10

College of Medicine
Private Bag 360
Chichiri
Blantyre 3
Malawi
Telephone: 677 245
677 291
Fax: 674 700
Telex: 43744

10th November, 2005

Mr Jimmy Gama
Centre for Reproductive Health
P/Bag 360
Blantyre 3

Dear Mr Gama,

RE: P.04/05/345 – Assessing youth – friendly reproductive health services and unmarried adolescents' sexual and reproductive health behaviour in Mangochi district.

I write to inform you that COMREC reviewed the response of the above mentioned protocol at its meeting of 26th October, 2005. I am pleased to inform you that your proposal was approved after considering that you addressed all the issues which were raised in an earlier review.

As you proceed with the implementation of your study I would like you to take note that all requirements by the college are followed as indicated on the attached page.

Yours sincerely,

Dr B. Makanani
VICE SECRETARY – COMREC

REQUIREMENTS FOR ALL COMREC APPROVED RESEARCH PROTOCOLS

1. Pay the research fees as required by College of Medicine for all approved studies.
2. You should note that the follow-up committee will monitor the conduct of the approved protocol and any deviation from the approved protocol may result in your study being stopped.
3. You will provide an interim report in the course of the study and an end of study report.
4. You are required to obtain a continuation approval after 12 months.
5. All investigators must be fully registered with the Medical Council of Malawi.

Ref. No.....

MINISTRY OF HEALTH
MANGOCHI DISTRICT HOSPITAL
P.O. BOX 42
MANGOCHI.

DATE: 24th May 2005

MINISTRY OF HEALTH
DISTRICT HEALTH OFFICER
2005 -05- 24
MANGOCHI DISTRICT HOSPITAL
P.O. BOX 42, MANGOCHI
MALAWI

TO: **DB Jimmy-Gama** (Research Student)
Centre for Reproductive Health
College of Medicine, Mangochi.

Cc: **Dr AM Chimbiri** (Director – CRH)
Centre for Reproductive Health
College of Medicine, Mangochi.

SUBJECT: A LETTER OF SUPPORT FOR USE OF DHO HEALTH FACILITIES' RECORDS

I am writing to inform you that permission has been granted to use some of the health facilities' service utilization records as a part of your data collection for a study on "Assessing Youth-Friendly Reproductive Health Services and adoption of preventive behaviours for STIs, HIV/AIDS and early pregnancies among unmarried adolescents in Mangochi District".

Wishing you all the best during your research.

Thank you,

G. T. SAIZI
For: District Health Officer

Annex 3A: **Participant Information Sheet**

Dear Participant,

I am Dixon Jimmy-Gama, currently involved in a research project addressing adolescent reproductive health. The project evaluates the capacity of youth-friendly reproductive health services to promote and facilitate the adoption of STI, HIV/AIDS and pregnancy prevention strategies among unmarried adolescents. This study is conducted as a partial fulfilment of the requirements for my Ph.D. degree in International Health at Institute for International Health and Development, Queen Margaret University, United Kingdom.

Your participation in this project will provide useful information on this topic. You qualify for participation if you are between the ages of ten and nineteen. You will be interviewed for a period of about one hour. The interviewer will take notes and the interview will also be tape-recorded. You may also be followed up in the near future if necessary to clarify some issues that may emerge during the analysis of the interview data.

Participation in this study is strictly voluntary. You may withdraw from the study at any point without penalty. All information collected is confidential and will be used for research purposes only. In addition, data collected will be anonymous.

Although there are no foreseeable risks to the study participants, the interviews will involve detailed questions that may be sensitive as they tackle mostly issues related to sexual and reproductive health behaviour. If you feel such questions would upset you, please feel free to decline at any point in this project.

Thank you for your assistance.

Dixon Jimmy-Gama

Annex 3B: **Kalata Yomudziwitsa Munthu Wotenga Mbali za Kafukufukuyi**

Okondeka,

Ine ndine Dixon Jimmy-Gama ndipo panopa ndili pakafukufukuwokhuza uchembere wabwino ndi kugonana modziteteza pakati pa achinyamata osokwitira/wa a zaka zapakati pa khumi (10) pakana khumi zisanu ndi zinayi (19). Cholinga cha kafukufuku ameneyu ndi kufufuza ngati kuyambitsa kwa ntchito ya uchembere wabwino ndi ulangizi wa kugonana modziteteza zathandiza kukopa achinyamata osakwatira/wa kuti athe kugwirits ntchito njira zomwe zingawateteze kumatenda opatsirana pogonana kuphatizapo HIV/Edzi komanso kupewa kutenga pakati mosakonzekera. Kafukufuku ameneyu athandiza kuuinikira oyendetsa ntchito zachipatala ndi ena onse omwe amagwira ntchito zokhudzana ndi umoyo wa achinyamata dongosolo lomwe ayenera kulitsata ngati afuna ntchito yawoyo ikathe kuthandize achinyamata kupewa matenda opatsirana pogonana ndi HIV/Edzi komanso kupewa kutenga pakati asanakonzekere.

Kutenga nawo mbali mukafukufuku ameneyu ndi kofunika kwambiri chifukwa zitithandiza kudziwa zambiri pa mutu umenewu. Ndinu oyenera kutenga nawo mbali ngati muli wachinyamata wa zaka kuyambira khumi (10) mpakana khumi zisanu ndi zinayi (19), kapenanso ndinu akuluakulu omwe mumakhala mdera lomwe lino, kapenanso ogwira ntchito mchipatala makamaka kumalo omwe amathandiza anthu za uchembere wabwino ndi ulangiza wa kugonana modziteteza kapenanso mumathandiza achinyamata pa nkhani ya uchembere wabwino ndi nkhani zokhuzana ndi kupewa matenda opatsirana pogonana ndi HIV/Edzi.

Mudzafunsidwa mafunso kwa pafupifupi ola limodzi. Yemwe adzakufunseni mafunsoyo azidzalemba komanso kujambula pa wailesi zomwe mu zidzakambirana.Ngati kudzakhale kofunika mudzatsatiridwa kuti mufotokonze mwatchutchutchunhkani zina zomwe zingaunikiridwe patsogolo.

Kutenga mbali kwanu mukafukufukuyu nkosakakamizidwa. Muli ndi ufulu kukana kapenanso kusiyira pakati kafukufuku asanathe ndiposimuzalandira chilango chilichonse.

Zokambirana zonse zidzasungidwa mwa chinsinsi komanso zizgwira ntchito yakafukufukuyi basi. Poonjezera apo zomwe mudzafotokoze zidzasungidwa popanda kudziwa dzina lanu.

Ngakhale palibe kuopsa kulikonse mukafukufukuyi, zokambirana zathu zidzakhuza mafunso ena amene mwina mungakhale omangika kuyankha kapena osasangalala nawo chifukwa ndi mafunso omwe akukhudza za khalidwe logonana ndi uchenmbere wa inu. Choncho ngati mukuona kuti mafunso oterewa angakukhumudwitseni, muli omasuka kukana kapena kutuluka ngati mumatenga nawo mbali m'kafukufukuyi. Komanso muli ndi ufulu kufunsa mafunso ena alionse okhuza kafukufukuyi.

Zikomo kwambiri chifukwa chotithandiza.

Dixon Jimmy-Gama

Annex 4 A: **Informed Consent for Participation in the Study**

This study evaluates the capacity of youth-friendly reproductive health services to promote and facilitate the adoption of STI, HIV/AIDS and pregnancy prevention strategies among unmarried adolescents.

As stated in the invitation to participate letter, the study has no foreseeable risks to the participants. The main potential benefits of the study are that it will contribute to scientific knowledge on the topic and the knowledge gained may also help in designing effective programmes aiming at improving adolescent reproductive health. No costs or payments are associated with participating in the study, but a token of thanks will be given to the participants.

Based on the information provided regarding the research project, I understand that:

1. The time required for the interview is about one hour.
2. I may be followed up for another interview if necessary.
3. The nature of my participation is interview/FGD (delete where not appropriate).
4. My participation is entirely voluntary and I may terminate my involvement at any time without penalty.
5. All my data are confidential and the data will be destroyed within five years after completion of the study.
6. The discussion may be tape recorded if I accept it to be so.
7. All data are for research purposes only.
8. If I have questions about the research, or if I would like to see a copy of the final findings of the study, I can contact the researcher by calling him on the number given or write him on the address given.

I **agree/do not agree*** to participate in this study. (*Delete where applicable)
Name of Subject: _____
Signature of subject/
Parent/guardian if subject under 16 years: _____ Date :_____
Signature of investigator: _____ Date : _____

Further information is available from

Name of investigator: Jimmy-Gama

Address: Institute for International Health and Development, Queen Margaret University, Queen Margaret University Drive, Edinburgh EH 21 6UU, UK

Telephone: +44 0131 474 000 (UK)
09 923 899 (Malawi –contact during field work)

Annex 4B: **Kuvomereza Kutenga Nawo Mbali M'kafukufuku**

Monga ndamvera mukalata yomwe ndawerega /mwandiwerengera ija, ndamvetsetsa kuti kafukufukuyi ndi wofuna kuunikira nyira zomwe achipatala angachite pothandiza achinyamata osakwatira/wa kuti asatenge matenda opatsirana pogonana ndi HIV/Edzi komanso kupewa kutenga pakati asanakonzekere.

Malinga ndi zina zomwe ndawerenga, ndamvetsetsa kuti

1. Kukambirana kwathu nkwa ola limodzi;
2. Mwina mutha kudzandifunsanso ngati pali zina mutaunikira zomwe tinakambirana kale;
3. Kutenga mbali kwanga nkosaumirizidwa ndipo ndingathe kusiye nthawi ina iliyonse yomwe ine ndafuna;
4. Zokambirana zathu ndi zachinsinsi ndipo ndi zogwiritsa ntchito yakafukufuku yekhayi basi;
5. Ngati pali funso nditha kufunsa nthawi ina iliyonse.

Choncho ine mwaufulu wanga ndafuna **kuvomera/kusavomera** kutenga nawo mbali kafukufuku ameneyi.

Dzina La Ofunsidwa : _____

*Signature ya ofunsidwa:*_____

*Dzina ndi Signature ya mboni womiirira ngati ali ndi zaka zochepera khumi zisanu nchimodzi :*_____

Tsiku Lofunsidwa: _____

Dzina la Wofufuza: _____

Tsiku Lofunsa: _____

Annex 5: Qualitative Data Collectors Training Programme
July 12-17th, 2004 Save the Children Conference Hall

PLAN OF ACTIVITIES

DAY 1

TIME	ACTIVITY
9.00 – 9.05 Am	Welcome Remarks by Maggie
9.05 – 9.10Am	Introductions and Objectives of the meeting (JG)
9.10Am – 9.30 Am	Brief Description of the Research Study (JG)
9.30 – 10 .30 Am	Introduction Qualitative Research (JG)
10.30 – 10.45 Am	Break
10.45 am– 12.30 pm	Techniques in Conducting In-depth Interview (MK) Film showing conduction of IDI (JG) Discussion: Observation on the Film (JG)
12.30 – 1.30 Pm	LUNCH
1.30 – 3.30 Pm	Overview of the Qualitative Tools (Semi-structured in-depth interview guide) Translation of the Guide – Chichewa and Chiyao How to Use the Guide (JG)
3.30-3.40pm	Tea Break
3.40-4.25 Pm	Practice on the Use of Guide (MK)
4.25 – 4.50 Pm	Discussion on the Practical Experience (JG)
4.50-5.00Pm	Summary of the Day Activities and end of the Day 1 Activities

DAY 2

TIME	ACTIVITY
8.00-8.30am	Logistics for Field Practice (MK)
8.30-12.00pm	Field Practice – Pilot (JG, MK)
12.00-1.30pm	LUNCH
1.30-3.00pm	Sharing Field Practice Experiences (JG, MK)
3.00-3.10pm	Tea/Coffee Break
3.10-4.30pm	Review of the Research tools Based on Field Experiences (JG)
4.30-5.00pm	Logistics for Field Work and End of Training (MK)

Annex 6: Youth Friendly Reproductive Health Study Household Listing Training Programme August 26 - 27, 2004

Day 1

Date	Time	Activity	Facilitator
26/8/04	8 – 8.30 am	Registration, Welcome Remarks, Introductions, Logistics and administrative issues	Maggie Kamabalame
	8.30 – 9.00 am	Expectations and group norms	Phillip Ng'ombaela
	9.00 – 9.30 am	Purpose and Process of the Survey	Jimmy Gama
	9.30 – 10.15 am	Household Listing Exercise	Jimmy Gama
	10 15 – 10.30 am	BREAK	
	10.30 am – 12.00 pm	Roles and Responsibilities of Household enumerators	Jimmy
	12.00 – 1.30 pm	LUNCH	
	1.30 – 3.00 pm	Identification of households and respondents and	Jimmy Gama

		marking households with eligible participants	
	3.00 – 3.15 pm	BREAK	
	3.15 – 4.30 pm	Filling the household listing Form	Jimmy
	4.30 pm	End of the Day	

Day 2

Date	Time	Activity	Facilitator
27/8/04	8 – 8.30 am	Recap	Philip Ng'ombaela
	8.30 – 9.30 am	Role Play Demonstration (Household listing) review	Jimmy
	9.30 – 9.45 am	BREAK	
	9.45 am – 12.00 pm	Field Practice	All Facilitators
	12.00 1.30 pm	LUNCH	
	12.00 – 1.30 pm	LUNCH	
	1.30 – 3.00 pm	Sharing field experiences	Jimmy
	3.00 – 3.15 pm	BREAK	
	3.15 – 4.30 pm	Preparation for Field work	All participants and facilitators
	4.30 pm	End of the Day	

Annex 7: Youth Friendly Reproductive Health Survey Data Collectors Training Programme August 31 – September 2, 2004

Day 1

Date	Time	Activity	Facilitator
31/8/04	8 – 8.30 am	Registration, Welcome Remarks, Introductions, Logistics and administrative issues	Maggie Kamabalame
	8.30 – 9.00 am	Expectations and group norms	Phillip Ng'ombaela
	9.00 – 9.30 am	Purpose of the Survey	Jimmy Gama
	9.30 – 10.15 am	Roles and Responsibilities of Data Collectors	Jimmy Gama
	10 15 – 10.30 am	BREAK	
	10.30 am – 12.00 pm	Identification of households and respondents	Adam Alide
	12.00 – 1.30 pm	LUNCH	
	1.30 – 3.00 pm	Interviewing Principles and techniques	Jimmy Gama
	3.00 – 3.15 pm	BREAK	
	3.15 – 4.30 pm	Review of Questionnaire	Jimmy/Maggie
	4.30 pm	End of the Day	

Day 2

Date	Time	Activity	Facilitator
1/9/04	8 – 8.30 am	Recap	Philip Ng'ombaela
	8.30 – 9.30 am	Continue questionnaire review	Jimmy/Maggie/ Adam
	9.30 – 10.15 am	Role Play Demonstration	Francis Khonyongwa
	10 15 – 10.30 am	BREAK	
	10.30 am – 12.00 pm	Practice of the	Jimmy

		questionnaire	(Groups of 4)
	12.00 – 1.30 pm	LUNCH	
	1.30 – 3.00 pm	Practice of the questionnaire continues	Jimmy (Groups of 4)
	3.00 – 3.15 pm	BREAK	
	3.15 – 4.30 pm	Practice of the questionnaire continues	Jimmy (Groups of 4)
	4.30 pm	End of the Day	

Day 3

Date	**Time**	**Activity**	**Facilitator**
2/9/04	8 – 8.30 am	Recap	Adam Alide
	8.30 – 10.15 am	Field Practice	Jimmy
	10.15 – 10.30 am	BREAK	
	10.30 am – 12.00 pm	Field Practice	All Facilitators
	12.00 1.30 pm	LUNCH	
	1.30 – 3.00 pm	Sharing experience of field work	Jimmy Gama
	3.00 – 3.15 pm	BREAK	
	3.15 – 4.30 pm	Preparation for data collection	ALL Participants and Facilitators
	4.30 pm	End of the Day	

END OF THE TRAINING

Annex 8: Data Entry Clerks Training Programme

September 8 - 9, 2004

Day 1

Time	**Activity**	**Facilitator**
9.00 -9.30 am	**Introduction** -Welcome remarks -Self introduction stating experience in data entry and expectations Norms and logistics	Allison Zakaliya
9.30 – 10.30 am	**Stages in a Research**	Jimmy Gama
10.30 – 10.45 am	Refreshments	
10.45 – 11.20 am	**Qualities of good data entry** **How to minimize data entry Errors**	Allison Zakaliya
11.20 – 11.40 am	**Monitoring movement of questionnaires** - Importance of monitoring - Use of monitoring sheets - Updating monitoring sheets - Double entry - Balancing questionnaires - Archiving data	Allison Zakaliya/ Jimmy Gama
11.40 am – 12.00 pm	**Back up** - Importance of back up - Methods and frequency of backup - Backup media storage	Jimmy Gama
12.00 -1.30 pm	Lunch	
1.30 – 2.00pm	**Data editing and coding** - Single response questions	Allison Zakaliya

	- Multiple response questions - Open fields - Skip patterns - Identifying inconsistencies	
2.00 – 2.30 pm	**Data collection, coding and editing practice**	
2.30 – 3.00 pm	**Data entry practice**	Allison /Jimmy
3.00 – 3.15 pm	Refreshments	
3.15 – 4.30 pm	**Data entry practice continues**	Allison/Jimmy
4.30 pm	End of the day	

Day 2

Time	**Activity**	**Facilitator**
9.00 -10.00 am	**Data entry practice**	Allison/Jimmy
10.00 – 10.15 am	**Refreshments**	
10.15 – 11.15 am	Setting up data entry system	Allison
11.15	**End of the Training**	

Annex 9: Household Listing Form

Name of Enumerator: _____ Listing date: _____
Name of Cluster: _____ ID of Cluster: _____

Household Number	Census house number	Name of household head for house	Mark with "X" if there is unmarried adolescents (10 – 19 years	**To be marked with "XX" if household would be selected into sample**
0001				
0002				
0003				
0004				
0005				
0006				
0007				
0008				
0009				
0010				

**Please, DO NOT write in the last column as it will be used after sampling of the households is done.

*** Please, write the direction or any identification for the area where numbering started from in the cluster in this space provided

Annex 10A: **Question Guide for Unmarried Adolescents**

Name of Interviewer: _____ Location: *YFRH/Non-YFRH* Date: _____

Source of Information

1. How knowledgeable do you feel about sexual matters?
2. How did you learn relationships, sex, contraception, STIs and HIV/AIDS? Do you feel that the information you have received has been adequate or there are anything you would like to learn more about as regards sex, pregnancy, contraception, STIs and HIV/AIDS?

Social Environment

3. What factors are there in your society that could influence young unmarried people's sexual and reproductive behaviour?
4. Do you discuss sex-related issues with your family members? What is discussed?
5. What influences do your peers have on your sexual and reproductive practices?
6. What roles do institutions like churches/mosques, schools and others play in shaping young people's sexual and reproductive behaviour?
7. What work-related issues do you think may also expose young people to unsafe sexual behaviour?

Sexual Relationships

8. What sexual activities have you engaged in? At what age did you start having sexual intercourse?
9. What factors or circumstances led to your first sexual debut? What factors led to your first penetrative intercourse?
10. What circumstances or factors could also make you to continue in engaging in unsafe sexual practices?
11. What factors have you been considering when choosing a sexual partner?
12. What effect has your awareness of your partner's sexual activity/history had on your sexual and reproductive behaviour?
13. What problems do you feel you face because of your sexual and reproductive behaviour?

Preventive Measures used

14. What prevention measures have you been using to prevent SRH problems: STIs, HIV/AIDS and early pregnancy? Why?
15. What measures have you been used to prevent SRH problems with your recent sexual partner? Why?
16. What factors could enhance or hinder you from adopting preventive measures from SRH problems?
17. Do you have time to discuss with your sexual partners issues related sex, contraception, STI, HIV/AIDS and early and unwanted pregnancy?
18. Have you heard about availability of YFRH services? Who uses these services and why?
19. What factors could facilitate or hinder unmarried adolescents from using YFRH services at the clinic?
20. What do you think could be done in order to attract more unmarried adolescents to SRH services at YFRH facilities?
21. How would you like the quality of services at YFRH facility to be like so that you would be interested to visit the facility?

For those with no Sexual Experiences ONLY

22. What factors made you to have no sexual experience?
23. How do you resist other forces that would make you to engage in sexual intercourse?

Annex 10B: **Mafunso a kwa Achinyamata osakwatira/wa**

Dzina la ofunsa_____ **Malo** YFRH/Non-YFRH **Date**_____

Tsiku:_____ **Mudzi**_____

1. Kodi mmene ukuonera umadziwa motani za nkhani ya kugonana?
2. Kodi unaphunzira motani za maubale, zogonana, kulera, matenda opatsirana pogonana kuphatikizapo HIV/Edzi?
   |Mmene ukuonerazimene wakhala ukumva ndi zokwanira kapena pali zina zomwe ungafune kuti uziimvetsetse pa mitu yomwe tafotokozayi?
3. Ndi zifukwa zotani mchikhalidwe chanu zomwe zimalimbikitsa achinyamata osakwatira/wa pa moyo wawo wokhudza kugonana komamnso uchembere wabwino?
4. Kodi umatha kukambirana nkhani za kugonan ndi abale ako? Nanga mumakambirana zotani?
5. Kodi achinyamata amzako amakhala ndi chikoka chotani pa moyo wako wokhudza kugonana ndi uchembere?
6. Kodi mabuyngwe monga a zipembedzo, sukulu ndi enaamatengapo mbali yotani polimbikitsa achinyamata pa moyo wa uchembere wawo?
7. Kodi ndi mfundo ziti zimene zikukhudzana ndi ntchito yomwe munthu amagwira zomwe zingaike moyo wake pa chiswe?
8. Kodi munayamba kugonana muli ndi zaka zingati? Nanga mumkachita zotani?
9. Kodi zifukwa zomwe zinakupangitsa kuti uyambe zogonana ndi zotani? Nanga kuti mugonane koyamba chinachitika ndi chiyani?
10. Kodi zifukwa zomwe ingsakupangitse kuti upitirize mchitidwe wogonana umene ungakubweretsere mavuto ndi chiyani?
11. Kodi nanga iwe ukafuna kusankha bwenzi ligonana nalo umalingalira mfundo zotani?
12. Kodi nanga mbiri ya mzako yemwe umagonana naye yakhudza bwanji moyo wako wogonana?
13. Kodi ndi mavuto otani ameneukuona kuti umakomana nawo chifukwa cha moyo wako wogonana ndinso uchember wako?
14. Kodi wakhala ukutsata njira zanji kuti upewe mavuto okhudzana ndi moyo wogonana kudzanso uchembere? Nanga ndi chifukwa chiyani umatsata njira zimezo?
15. Kodi nanga pamene unapeza bwenzi lako limene uli nalo padakali pano wakhala ukutsata njira zanji kuti upewe mavuto okhudzana ndi moyo wogonana kudzanso uchembere? Fotokoza zifukwa zimene zinakupangitsa kutero?
16. Kodi pali zifukwa zotani zimene zingalimbikitsekapena kulepheretsa achinyamata kuti atsate makhalidwe opewa mavuto osiyanasiyana okhudza uchembere wawo?
17. Kodi umakhala ndi nthawi yokambirana ndi nzako wogonana naye nkhani zokhudza kugonana, kulera , matenda opatsirana pogonana, HIV/Edzi komanso kutenga pakati mosakonzekera?
18. Kodi unamvapo za kapezekedwe ka chisamaliro cha ku chipatala chokhudza achinyamata omwe amafuna chithandizo pa uchembere wawo? Nanga ndi anthu otani amene amakhala ndi mwayi olandira chithandizo choterechi?
19. Kodi ndi zifukwa zotani zomwe zimapangitsa kapena kulepheretsa achinyamata osakwatira/tiwa kuti alandire chithandizo chokhudza uchembere wawo pa chipatala chanu chino?
20. Kodi mukuganiza kuti tingataniku pofuna kukopa achinyamata ambiri osakwatira/wa kulandira chithandizo chokhudza uchembere wawo ku zipatala zomwe ziri ndi ndondomeko yosamalira achinyamata pa moyo wawo wa uchembere?

21. Kodi munakakonda kuti a chipatala azikulandirani motani kuti mukhale ndi chidwi chopita kukalandira chithandizo cha uchembere wanu?

Kwa amene sanagonanepo ndi munthu wina aliyense

22. Kodi chimene chinakupangitsa kuti ukhale odzisunga osagonana ndi chiyani?
23. Kodi umatha bwanji kukana pamene ena ukukopa kuti uyambe zogonana?

Annex 11A: **Question Guide for Adult Community Members**

Name of Interviewer: _____ Location: *YFRH/Non-YFRH* Date: _____

1. What is the definition of an adolescent in your society?
2. What processes does an adolescent require to go through in order to become an adult?
3. What are the social expectations of unmarried adolescents regarding issues of sexuality and reproduction?
4. How do young people learn about sexuality and reproduction in your society?
5. What are the attitudes of adult community members towards unmarried adolescents' sexuality and reproduction?
6. How would you describe the sexual and reproductive health problems facing unmarried adolescents in your community? Comment on occurrence of STI, HIV/AIDS and early and unwanted pregnancies.
7. What are the factors that might be influencing unmarried adolescents to engage in unsafe sexual and reproductive practices?
8. What measures do people in your community use to avoid contracting STIs, HIV/AIDS and unwanted pregnancy?
9. Do people in your society use health facilities for their health care? What services are commonly used and why? Who can use the services?
10. What are the community attitudes towards provision of SRH services like condoms and contraceptives to unmarried adolescents?
11. What roles do the community take in order to assist unmarried adolescents prevent STIs, HIV/AIDS and early and unwanted pregnancies?
12. Have you ever heard about youth friendly reproductive health services? What have you heard? What are the factors that might be influencing the unmarried adolescents to use or not to use YFRH services in your community?
13. If you have heard about YFRH services, what role did your community take in the initiation and designing of the programme? Did the youth in your society participate in the initiation? What role did they take?
14. What do you think could be done in order to attract more unmarried adolescents to use YFRH services?
15. What role has your government/political system's roles in promoting sexual and reproductive health for the youth?

.*Annex11B*: **Mafunso a kwa Akuluakulu (Mausyo ga kwa achikulungwakulungwa) – in Yao**

1. Ana malowe gati Nchanda gasagopolera chichi mu ndamiro syawo?
2. Ana tusajembecheraga kuti Nchanda akwanirisye yindu yapi kuti tunjitichisye yati akusile?
3. Ana wachinyamata wangalombera asajembecheraga yanti uli pa ngani ja gonana in uchembere?
4. Ana mu ndamiro syao, achinyamata akulijiganya uli pa ngani sya gonana in uchembere?
5. Ana achakulungwa wa mdera mwao akusaganichisyaga yanti uli achinyamata pa ngani ja gonana in uchembere?
6. Ana mpaka alongosole mwantiuli ya yakusausya ya wachinyamata nasikana mmusi muno pa mbali ja ilwele yakupatikana kupitila mbali jagonana mpela HIV/Edzi in yakusausya ya kupata chitumbo changakosechela pakati pa achinyamata nasikana wangalombela?

7. Ana magongochi gasalimbikasyaga wachinyamata wangalombela kuti atendeje nsese ni ndamosyakusokonesya uchembere wawo?
8. Ana wandu wa m'musi uno akasakuyaga matalachi pakusaka kuliteteya ku chitumbo changakonzechera, ilwele yakuperegana kupitira mchikululu in HIV/Edzi?
9. Ana wachinyamata wa dera jino akusajala ku chipatala pa isausyo yakulekangalekangana yapa umi wao wauchembere?
10. Ana wandu wadera jinoakusatiga uli pa masengo gakupeleka matala ga yakulera kuwanganya ni makondomu kwa anyamata nasikana wangalombera?
11. Ana wandu wadera jino akutenda chichi pakusaka kwakamuchisya anyamata wangalombera kuti aliwambasye kuitumbo yangakosechera kapena itumbo yakujigala kanakomale in ilwele yakutapula pagonana in HIV/Edzi?
12. Ana waipikene kuti pana mpango wakwakamuchisya anyamata nasikana paumi wao wakwenera, mwakwenera? Waipikene yati uli? Yindu yapi yakuti mpaka yatende kasye anyamata nasikana wangalombera kuti akamulisye kapena akakamulisya masengo chikamuchisyo chakuchipatala chakwayana niuchembere wao mdera jawo?
13. Naga waipikene yampango wakupereka chikamuchisyo kwa anyamata nasikana, wandu wadera jino wajigere mbali japi pakutandiya masengoga? Nambi anyamata nasikanawa wajigere mbalichi?
14. Akuganichisya kuti jere mipangoji jitendekwe mwanti uli kuti jikopeje anyamata nasikana wajinji wangalombera kuti akamulisye masengo chakamuchisyo chauchembere wambone wa anyamata nasikana kutyochera m'chipatala?
15. Ana boma lipite kapena lipali likamuchisya mwantiuli pakusaka kukwesya umi wa anyamata nasikana kuti aliteteye ku ilwele yakutapula pagonana kuwanganya pampepe in HIV/Edzi nambo soni kuliteteya kujigala chitumbo changakosechera?

Annex 12A: **Question Guide for Health Service Providers**

Name of Interviewer: _____ Location: *YFRH/Non-YFRH* Date: _____
Facility Type: *Public/Private*

1. What SRH services are provided at your facility? Who can access these services?
2. What guidelines/policies does your facility use for the provision of SRH services to the youth? Do these guidelines consider unmarried adolescents as an important group to receive SRH services?
3. What factors do you think affect unmarried adolescents' utilisation of SRH services at your facility?
4. What measures are taken to ensure that quality services to the youth including unmarried adolescents? From whose point of view is the definition of quality care based - clients or the providers?
5. What are the attitudes of the health service providers towards provision of SRH services to unmarried adolescents?
6. How would you describe the availability of supplies and other resources for the operations of the facility?
7. What problems does your facility face in the provision of SRH services to the youth? Why?
8. What procedures do you follow when a youth client visit your facility for SRH services? – ask also about confidentiality, privacy, physical examination, follow up care.
9. What comment would you give on the effect of the location and setting of your clinic to attracting unmarried adolescents to use the services?
10. What would you say is the government/political commitment towards promotion of YFRH services?
11. What strategies are used to mobilise the community and the youth about the availability of YFRH services?

12. What measures do you have in place to promote gender equity and equality to eliminate gender-based discrimination during service provision?
13. What cadre of staff do you have at your facility? Are both male and female providers available? What about youth counsellors?
14. What do you think has been the role/effects of the community in supporting/encouraging unmarried adolescents to use SRH services at your facility?
15. How did your facility initiate the YFRH programme? Who were involved in the designing of the programme? What roles did each stakeholder play?
16. In your opinion, what has been the effect of YFRH service provision on the rate of utilisation by unmarried adolescents?
17. What do you think can be done in order to promote utilisation of SRH by unmarried adolescents?

Annex 12B: **Mafunso a anthu ogwira ntchito mzipatala**

Dzina la ofunsa_____ **Malo** YFRH/Non-YFRH **Date**_____
Tsiku:_____ **Mudzi**_____
Chipatala: Cholipira/chosalipra

1. Kodi ndi zithandizo ziti zomwe mumapereka pachipatala pano pokweza uchembere wabwino ndi kugonana modziteteza? Ndani ali ololedwa kulandira chisamaliro/chithandizo chimenechi?
2. Kodi chipatala chino chimagwiritsa ntchito malamulo kapena ndondomeko zotani popereka zhithandizozi kwa achinyamata? Nanga malamulo amenewa amaganizira motani achinyamata osakwatiwa/ra monga gulu limodzi loyenera kulandira chithandizo chimenechi?
3. Ndi zifukwa ziti zomwe mukuganiza kuti zimawapangitsa kapena zimawalepheretsa achinyamata kudzalandira chithandizo chokhudza umoyo wao wa uchembere wabwino komanso kugonana modziteteza pa chipatala pano?
4. Pali njira zotani zomwe mumatsata pofuna kuwonetsetsa kuti achinyamata osakwitiwa/ra akusamalidwa moyenera pachiptala pano? Kodi pofotokoza tanthauzo lachisamaliro chapamwamba, zimatengera momwe olandira chithandizo akumvera kapena opereka chithandizo?
5. Pali njira zotani zomwe mumachita pofuna kuwakopa achinyamata osakwatira/wa kuti aziubwera pachipatala pano kuzagwiritsa ntchito zithandizo zowathandiza kupewa matenda opatsirana pogonana kuphatikizapo HIV/Edzi komanso kupewa kutenga mamba asanakonzekere?
6. Kodi mukuganiza kuti anthu a mchipatala opereka zithithandizozi amamva bwanji popereka zithandizozi kwa achinyamata osakwatiwa/ra kuti akhale ndi uchembere wabwino ndi kugonana modziteteza?
7. Kodi mungafotokoze motani pa kapezekedwe ka zipangizo ndi zinthu zina zoyenerapogwira ntchito yanu mchipatala chino?
8. Kodi mumakumana ndi mavuto otani pofuna kuti muthandize moyenera achinyamata osakwatiwa/ra? Nanga nchifukwa chiyani?
9. Kodi pali ndondomeko yotani yomwe mumatsatira achinyamata osakwitira/wa akabwera kudzalandira chithandizo? *Funsaninso ngati pali malo otha kukambirana mwachinsinsi, kusunga zolembedwa zonse mwachinsinsi, kuwayeza m'thupi mwawo, komanso ndondomeko yoti achinyamata akhathe kubweranso kuchipatala mtsogolo.*
10. Kodi muli ndi ndemanga yotani pa nkhani ya malo omwe chipatala chanu chilli komanso momwe zipinda zogwiliramo ntchito ziliri pokopa achinyamata osakwatira/wa kuti azigwiritsa ntchito zithandizo zanu?
11. Kodi boma/ulamuliro wakhalapo kapena umene ulipo ukuthandiza motani pofuna kukweza moyo wa achinyamata kuti apewe matenda opatsirana pogonana kuphatikizapo HIV/Edzi komanso kupewa kutenga pakati zosakonzekera?
12. Ndi njira zanji zomwe zikugwiritsidwa ntchito polimbikitsa achinyamata ndi anthu ena onse kuti azitenganao mbali polimbikitsa achinyamata osakwatiwa/ra kuti azigwiritsa ntchito njira

zopewera kutenga matenda opatsirana pogonana komanso kupewa kutenga pakati asanakonzekere?

13. Kodi pali pongosolo lotani pofuna kuwalimbikitsa achinyamata aakazi ndi aamunakuti onse azibwera kuzalandira zithandizo za uchembere wabwino ndi kugonana modziteteza mchipatala chanu?
14. Kodi pachipatala chino pali anthu aluso ndi ukatswiri otani omwe amawathandiza achinyamata osakwitira/wa akabwera? Kodi anthu amenewa ndi osakanikirana amuna ndi akazi? Nanga achinyamata aliponso? Amagwira ntchito yotani?
15. Kodi anthu a mdera lino atengapo mbali yotani pofuna kuimbikitsa ndi kuthandiza achinyamata osakwatira/wa kuti azipita kukalandira chithandizo kuti apewe matenda opatsirana pogonana komanso kupewa kutenga pakati asanakonzekere?
16. Kodi ntchito ya uchembere wa achinyamata munaikhazikitsa bwanji pachipatala chino? Ndi anthu ati omwe anakhudzidwa nayo ndipo ndi magawo ati omwe anatengapo pa ntchitoyi?
17. Mmaganizo anu mukuona ntchito ya uchembere wabwino ndi kugonana modziteteza pakati pa achinyamata yalimbikitsa bwanji chiwerengero cha achinyamata osakwatira/wa obwera kuchipatala chino kudzafuna zithandizo zimenezi?
18. Mukuganiza kuti tingachite bwanji pofuna kulimbikitsa achinyamata ambiri osakwatira/wa kuti azigwiritsa ntchito njira zopewera matenda opatsirana pogonana ndi HIV/Edzi ndi kupewa kukhala ndi pakati mosakonzekera?

Annex 13: **PARTICIPANT OBSERVATION CHECKLIST**

Providers and Staff

Characteristics	Yes	No	Comments
Staff is friendly and responsive to youth clients			
Staff is respectful to and ensures privacy of youth clients			
Staff is understanding of and knowledgeable about youth concerns and needs			
Counselors spend adequate time with youth clients			
Counselors use language that is understandable to youth			
Conselors are non-judgemental and approachable			
Medical providers spend adequate time with youth clients			
Medical providers use language that is understandable to youth			
Medical providers are non-judgemental and approachable			
Information provided during counseling is clear and helpful			
Information on need for and timing of follow-up visit(s) is provided and clear			
Medical providers offer choices, including abstinence, contraception and withdrawal			
Adequate number of staff available			

Implementation of Policies

Characteristics	Yes	No	Comments
Youth drop-ins are welcome and accommodated (without appointment)			

No long waiting time for clients			
Youth clients do have time to discuss issues related to their SRH			
Services are offered to both male and female youth clients			
Facility provides informational and/or audio-visual materials on RH services and concerns for youth clients			
Facilitates provides/stocks contraceptive methods that are most popular among youth clients			
Services are provided on rights-based approaches			
No consent is required for any service			
Youth with STI are forced to bring their partners for them to get treatment for STI			
Medical procedures/examinations are not done by compulsory for clients to receive contraceptives			
Facility offers wide range of services			
Measures to promote continuity of service utilisation is in place			
Clients informed of the alternative sources of services in their community			
Youth involved in service design and delivery			
Clinics are operational at convenient time for youth			
Services are linked to other youth service and programme networks			
Cost of RH services is affordable/free			
Medical supplies and contraceptives are always available			
Policies and strategies for mobilising youth are in place			
YFRHS are accessible to youth (location, distance)			
Community is involved in programme design, monitoring and evaluation			

Environment and Facilities

Characteristics	Yes	No	Comments
ARH are provided at convenient hours for youth clients			
Décor and surroundings are inviting to youth clients (i.e. non-medical)			
Location of the YFRH clinic ▪ Close to public transportation ▪ Far away from places where adult spend most of their time ▪ Close to places where unmarried youth spend their time e.g. schools, video centres, recreation centres ▪ Close to place where the general public			

is often found			
Counseling and examination rooms ensure privacy for youth clients			
Separate space or time is used for youth clients			
Facilities are conveniently located for youth			
Education materials are displayed and available to youth clients			
Youth clients show overall satisfaction with environment at the clinic			
Visual and auditory privacy maintained during counseling and other procedures			

Behavioural Change and Communication Information

Characteristics	Yes	No	Comments
Greater clarity of the information imparted to clients – accurate and non-technical language			
What information is provided about pregnancy prevention STI/HIV/AIDS prevention strategies ▪ Effectiveness ▪ Side effects ▪ Advantages and disadvantages ▪ Correct use ▪ Follow-up ▪ Complications ▪ Clients assured of confidentiality			
Sensitivity to verbal and non-verbal communication by provider			
Counselor engage in dynamic interactions with much less telling and more listening, asking, responding, encouraging, establishing rapport and clarifying			
Encouraging clients to ask questions and seeking clarification			
Provider eliciting needs of a client, prioritise information to make it more relevant to the individual and empower client to make the decision about the solution to their problem			
Clients are not overloaded with information – only relevant information is given to them			
Provider has time for exploring clients' situations, questions and answers and checking for comprehension of the clients			
Providers inquire of client's risk perception of STI, HIV/AIDS and pregnancy			
Use of visual aids/memory aids and correctly used			
Issues of sexuality and gender discussed			

Services

Characteristics	Yes	No	Comments
Services available			

▪ Counseling ▪ Contraceptive methods *(comment types)* ▪ Condoms ▪ Emergency Contraception methods ▪ IEC ▪ Premarital counseling ▪ STI treatment ▪ Follow-up			
Both male and female adolescents welcomed and served			
Unmarried adolescents welcomed and served			
No discrimination in service provision (married and unmarried youth)			
Services commonly used *(Comment on what services)*			
Unmarried adolescents often visit the clinic			
Individualised care promoted and provided			
Youth involved in decision-making regarding their care after providing adequate information on different options of treatment/methods			
Clients given their preferred treatment/methods (contraceptive)			
Provider forces clients to use particular treatment/method			
Services provided with the requirement for consent from other people other than the clients			
Medical procedures (pelvic examinations and blood tests) are delayed			
Provider counseling on importance of treating clients' partners if they have STIs			
Referral services available when necessary			
Providers identify and make plans for young people who require special support ▪ Young woman whose partner is opposed to use of contraceptive ▪ Young people who lack negotiation skills ▪ Victims of sexual violence ▪ First time users ▪ Subsequent users who are defaulting			
Handling of first time users at the clinic ▪ Friendly welcome ▪ Orientation and education on services provided ▪ Education on their rights to use the services ▪ Assurance of confidentiality ▪ Times of operations ▪ Provision of IEC leaflets on SRH and			

YFRH operations ▪ Assessment of client's reason for visiting clients ▪ Provision of services to clients with their involvement in decision-making regarding treatment ▪ Encouragement of continuity and arrangement of follow-up ▪ Information on location of similar services in his/her locality/community ▪ Avoiding making judgement about clients' sexual behaviour ▪ Encouraging to join youth SRH groups			
Handling of subsequent users ▪ Friendly welcome ▪ Follow-up of previous services for any problem or effectiveness ▪ Assessing client's current needs ▪ Counseling and education ▪ Provision of care ▪ Follow-up arrangement			
Steps followed when managing a client (Six 'A's) ▪ Ask about client's sexual history ▪ Assess client's risk perception ▪ Assess client's motivation to change sexual behaviour ▪ Advice or counsel on risk prevention measures ▪ Assist/Facilitate behaviour change by encouraging clients ▪ Arrange follow up			

Annexe 14A: **Client Exit Interview Questionnaire - English**

Introduction
My name is _____ and I am studying at Queen Margaret University College, UK. I am interested in what youth think about reproductive health services provided at this facility and would like to know your feelings about the service that you just received. I would like to ask you a few questions about the meeting you have just had with the facility staff and would be very grateful if you could spend a little time talking with me. I will not write down your name, and everything you tell me will be kept strictly confidential. Your participation is voluntary, and you are not obliged to answer any questions you do not want to. Do I have your permission to continue?

Instruction
Write the respondent's answers by either making a tick in the appropriate box or writing on the provided lines.

Background Characteristics of Health Facility

1. Name of YFRH health facility _____
2. Date of interview _____ Interviewer :_____
3. Level of facility where observation took place

a. District level ☐
b. Health Center level ☐
☐

4. Type of facility (Tick appropriately)
a. Government ☐
b. CHAM ☐
c. MAM ☐
d. NGOs ☐

5. Structure of facility
a. Youth-only facility ☐
b. Youth-only facility hours ☐
c. Integrated services ☐

6. Locality of facility
a. Urban ☐
b. Rural ☐

Background characteristics of Client

7. Sex :
a. Male ☐
b. Female ☐

8. Age: _____

9a. Currently schooling:
a. Yes ☐
b. No ☐

9b. What was your last year you attended school? _____

10. Highest level of education _____

11a. Do you have sexual experience
a. Yes ☐
b. No ☐

11b. At what age did you have first sexual experience? _____

12a. Have you ever used SRH services?
a. Yes ____
b. No _____

12b. If response to 12a is YES, when did you first use SRH services?
a. Before first sexual experience _____
b. After first sexual experience _____

12c. What SRH service was used?
a. Contraceptive ____
b. Condoms _____
c. Others (specify) _____

12d. If you started using SRH services after your first sexual experience, what was the reason?
a. Ignorance ___
b. Lack of services ____
c. Lack of motivation by others ___
d. Fear of stigmization in society __
e. Fear of parents ___
f. Others (specify) _____

13. Have you ever had a child?
a. Yes ☐
b. No ☐

Information about Services

14. Why did you come to the facility today (*Multiple responses allowed)*

a. Contraceptive counseling _____
b. Contraceptive collection _____
c. STI screening ____
d. VCT services ____
e. STI treatment____
f. Peer counseling _____
g. Abortion-related services ____
h. Pregnancy test____
i. Prenatal care _____
j. Nutrition Counseling ___
k.Premarital sex counseling____
l. Infertility consultation ____

15a. Were you able to speak to a counselor or a provider?

a. Yes ☐
b. No ☐

15b. If your answer to question above is YES, how were you assisted?

_____
_____

15c. During your visit, how would you generally describe your treatment by the provider?

a. Very well _____
b. Well _____
c. Not very well/poorly ____
d. Never assisted me ____

16. Were you satisfied with the treatment /management? Give reasons for your response.

a. Yes ___
b. No ____

Reasons:

_____
_____

17. What things did you have to go through before seeing a provider?
Did you have to ☐

a) Fill out some paper work/Registration
b) Listen to a health talk ☐
c) Others (specify) _____

18. About how long did you wait between the time you first arrived at this facility and the time you saw the provider?

a. Less than 15 minutes ☐
b. About 30 minutes ☐
c. About an hour ☐
d. More than one hour ☐

19. Do you feel that the waiting time was reasonable or too long?

a. No waiting time ☐
b. Reasonable/short ☐
c. Too long ☐
d. Don't know ☐

20a. Did you require an appointment to see the provider/counselor?

a. Yes _____
b. No _____

20b. If yes to question 20 a, how long did you require to make an appointment to see the provider?

a. A few hours ___
b. A day ___
c. A few days ____
d. A week ____

e. More than a week ___

20c. Was this fine with you?

a. Yes __
b. No __

20d. What would have been an appropriate amount of time to wit from making an appointment and seeing a provider/counselor?

a. A few minutes ___
b. A few hours ___
c. One day ____
d. A few days ____
e. More than a week __
f. None required ____
g. Others (specify) ____

20e. Did this delay you to see the counselor/provider?

a. Yes __
b. No __

20f. If response to 22d is yes, what measures were you using to prevent/alleviate your problem before meeting the counselor/provider?

_____
____

21. Length of the counseling/consultation session (Estimate)

Length of session: _____ Minutes

22. Do you feel that your consultation with the provider was too short, too long, or about the right amount of time?

a. Too short _____
b. Too long _____
c. About right _____
98 Don't know ____

23. Sex of provider:

a. Male ☐
b. Female ☐

24. Could the sex of the service provider affect the way you could use reproductive health services?

a. Yes ☐
b. No ☐

25. If response to above is YES, in what way?

_____

26. Was the provider who saw you a:

a. Clinician ☐
b. Nurse/midwife ☐
c. Counselor ☐
d. Peer educator ☐
e. Other (specify) _____.
f. Don't know ☐

27. Did the provider greet you in a friendly fashion?

a. Yes ☐
b. No ☐

28. Explain the reasons to your response in 23 above

_____
_____

29. Did the provider ask you the reason for your visit?

a. Yes ☐
b. No ☐

c. Don't know ☐

30. How did the provider react (what did he/she say) when you told him/her the reason for your visit (probe for more information)

_____

_____

31. How did you feel and why?

_____

_____*(Probe: Was the provider's reaction in 25 above acceptable or appropriate or not)*

32. How many times have you been visiting the clinic for YFRH services? ***(Circle appropriate response)***

a. First time
b. More than once
c. More than three times
d. Others (specify) _____

33a. Would you return to the clinic?

a. Yes ☐
b. No ☐

33b. Why would you do so?

_____

_____

34. Did you discuss any of the following topics with the provider? (Tick all that apply)

a. Your sexual history ☐
b. Your current sexual status ☐
c. The nature of your relationship with your current partner ☐
d. Your current and/or past contraceptive use ☐
e. Any HIV/AIDS/STI prevention measures ☐

35a. Do you feel the provider took your concerns seriously?

a. Yes ☐
b. No ☐

35b. Did you have any concerns on reproductive health issues that you wanted to discuss with the providers but was not tackled?

a. Yes ___
b. No ____

35c. If yes, what was it? _____

35d. Why didn't you discuss those issues with the provider/counselor?

_____

36a. Did the provider ask you questions about yourself?

a. Yes ☐
b. No ☐

36b. If yes, what kinds of questions did the provider ask?

_____

_____

37. How much information did the provider give you about any of the following:

(KEY: 0=none 1=minimum 2=moderate 3=extensive)

i. Family planning methods _____
ii. HIV/AIDS _____
iii. Other STIs _____

38. Did the provider ask whether you know about these topics before giving you

information?

a. Yes ☐
b. No ☐
c. Don't know ☐

39. Did the provider use any of the following visual aids during the sessions?

(KEY: 1=yes 2=no 98=don't know)

a. Posters _____
b. Drawings _____
c. Booklets _____
d. Videos _____
e. Models/Dolls _____

40a. Did the provider give you his/her personal opinion on what you should do?

a. Yes ☐
b. No ☐

40b. If yes, what was his/her opinion regarding your situation?

_____
_____

41a. Were you involved in making decision regarding your treatment?

a. Yes ☐
b. No ☐

41b. What role do you play in making decision regarding your treatment/management?

_____
_____

42. Did the provider ask you if you had any questions?

a. Yes ☐
b. No ☐

43. Did the provider respond to your questions?

a. Yes ☐
b. No ☐

44a. Did you feel comfortable asking the provider questions?

a. Yes ☐
b. No ☐

44b. If no, why not?

_____

45. Was the information given by the provider clear ad simple?

a. Yes ☐
b. No ☐

46a. Was anything the provider said confusing or unclear?

a. Yes ☐
b. No ☐
c. Don't know ☐

46b. If answer to above was YES, what was the confusion and why?

_____
_____

47a. Did you show or inform the provider that his/her information was not clear?

a. Yes ☐
b. No ☐

47b. If yes to the above question, what did the provider do?

_____
_____

47c. Did the provider respond to your questions to your satisfaction?

a. Yes ___

b. No __

48. Did the provider check to make sure you understood the information properly?

a. Yes ☐
b. No ☐
c. Don't know ☐

49a. Do you feel that the provider spend enough time with you?

a. Yes ☐
b. No ☐

49b. If no, why not?

_____
_____

50a. Did the provider do or say anything that made you feel uncomfortable?

a. Yes ☐
b. No ☐

50b. If yes, what was it ? _____

51a. Did the provider do or say anything during your visit that led to believe he/she did not approve of something you said?

a. Yes ☐
b. No ☐

51b. If yes, what did the provider do or say to make you feel this way?

_____
_____

52. If response to 16 is no, what were the reasons?

a. Facility was closed ☐
b. Counselor/provider was not at the facility ☐
c. Counselor /provider had no available appointments ☐
d. Counselor/provider refused to see client ☐
e. Other (specify) _____
f. Don't know ☐

53. If you were not able to see a counselor/provider, were you given appointment for a later date?

a. Yes ☐
b. No ☐

Operational Environment

54a. Are the attitudes of providers and staff supportive towards giving SRH services to youth?

a. Yes ___
b. No ____

54b. What reasons/evidences could you give for your responses above.

_____
_____

55a. Are boys and girls welcomed, served and treated in similar way?

a. Yes ____
b. No _____

(NOTE TO INTERVIEWER: ASK QUESTION 55b TO BOYS ONLY)

55b. Did you get the impression that the facility focuses more on female clients?

a. Yes ☐
b. No ☐

55c. If yes, what were the reasons for your impression?

_____

_____56a. (If provider was female/male) did you feel uncomfortable seeing a female provider? (*See response in question 19 and ask if necessary)*

a. Yes ☐
b. No ☐

56b. If yes, why?

_____

57a. Were the hours and day that you came to the facility convenient for you?

a. Yes ____
b. No _____

57b. If not, why not?

_____

57c. Is there another time or day that would have worked better you?

a. Yes ____
b. No _____

57d. If Yes, what would they be? _____

58a. Could anyone overhear the conversation you had with the provider?

a. Yes ☐
b. No ☐
c. Don't know ☐

58b. If YES, why?

_____

59a. Did anything occur to interrupt your discussion with the provider?

a. Yes ☐
b. No ☐

59b. If yes, what?

_____

60a. Did you meet with the provider in a separate room?

a. Yes ☐
b. No ☐

60b. If yes, describe it.

_____

61a. Did you feel that when you were meeting the provider it was very private?

a. Yes ☐
b. No ☐

61b. Explain your response above

_____

62a. Do you believe that the information you shared with the provider will be kept confidential?

a. Yes ☐
b. No ☐

62b. If no, why do you think so?

_____

63a. What about the receptionist, or anyone else who was working there, do you think that they will keep your information confidential?

a. Yes ☐
b. No ☐

63b. What is the reason for your response above?

_____

63c. Did other people/staff do or say anything that could make you uncomfortable?

a. Yes ___
b. No ___

63d. What was it?

_____

64. Did the provider:

		Yes	No
a.	Require you to get parental consent for any service?	☐	☐
b.	Require you to get spousal consent for any service?	☐	☐
c.	Inform you that you were too young to receive any of the services?	☐	☐
d.	Require you to have a blood test before giving you contraceptives?	☐	☐
e.	Require you to have a pelvic exam before giving you contraceptives?	☐	☐
f.	Require you to make another appointment before receiving a service?	☐	☐

65. Did the provider ask you to return for another visit?

a. Yes ☐
b. No ☐

66. Did you set a date for your next appointment?

a. Yes ☐
b. No ☐

67a. Was there anything that could affect you to use SRH services? *(Probe affordability/cost, distance, access etc)*

a. Yes ____
b. No _____

67b. What are those factors? _____

68a. What were your impression about the facility, itself? (*Probe: ask about waiting room and other rooms that the client visited, environment, staff attitude ,reception, procedures/processes carried out at the clinic etc*)

_____

69. Were there any educational materials available in the room?

a. Yes ☐
b. No ☐

70. What topics did the materials cover?

a. Pregnancy ☐
b. STIs ☐
c. HIV/AIDS ☐
d. Contraceptive methods ☐
e. Nutrition ☐
f. Parental/postnatal care
g. Other (specify) _____ ☐

71. Were there any signs or posters specifically targeting youth in the waiting room?

a. Yes ☐
b. No ☐

72. What massages were these materials trying to deliver?

_____

73. What do you think needs to be improved at the facility to attract more youth?

_____

74a. Would you recommend this provider to a friend?

a. Yes ☐
b. No ☐

74b. What are the reasons for your response in the question above?

_____

75. Is there anything else you would like to add regarding your visit?

_____

Thank you very much for your time and help!

Annexe 14B: **Client Exit Interview Questionnaire - Chichewa**

Mau Otsogolera

Dzina langa ndi _____ ndipo ndine wophunzira pa koleji ya Queen Margaret University ku United Kingdom. Ndiri pa kafukufuku yemwe cholinga chake ndi kufuna kufufuza zinthu zimene zimawapangitsa achinyamata osakwatiwa/ra kuti azigwiritsa kapena atsamagwiritse njira zomwe zingawateteze ku matenda opatsirana pogonana kuphatikizapo HIV/AIDS komanso kutenga pakati posakonzekera. Panopa ndiri ndi chidwi chodziwa m'mene akuthandizirani muchipatalamu lero. Choncho ndikufuna ndikufunseni za ulendo walero m'mene mwachedzera ndi adokotala.

Ndikhala osangalala mutandilora kuti tikambirane mu kanthawi kochepa. Ine sindilemba dzina lanukomanso zomwe mundiuze zikasungidwa mwachinsinsi. Kutenga mbali kwanu mu kafukufuku ameneneyu nkosakakamiza ndipo muli ndi ufulu oyankha mafunso omwe muli omasuka kutero. Mundilora kuti ndipitirize?

Lamulo loyankhira mafunso

Lembani pa mizere yomwe mwapatsidwa kapena lembani mozungurira malembo omwe ali koyambirira ngati mwapatsidwa mayankho oti musankhepo (e.g a. b. etc)

MBIRI YA CHIPATALA

1. Dzina la chipatala _____
2. Tsiku lokambirana _____ Wofunsa _____
3. Kukula kwa chipatala
   a. Chachikulu cha paboma
   b. Chipatala chaching'ono
4. Mtundu wa chipatala
   a. Chaboma
   b. Cha mishoni
   c. Cha Asilamu
   d. Cha mabungwe omwe si aboma

5.Dongosolo la pachipatala
   a. Cholola achinyamata okhaokha
   b. Cholola achinyamata okha kwa maola ena
   c. Cholola aliyense
6. Malo komwe kuli chipatala
   a.Kumidzi
   b.Kutauni

MBIRI YA OFUNA CHITHANDIZO KU CHIPATALA

7. Wamwamuna kapena wamkazi
   a. Mamuna

b. Mkazi

8. Zaka _____

9a. Muli pa sukulu

a. Inde

b. Ayi

9b. Ngati munasiya, ndiliti? _____

10. Munalekeza kalasi yanji? _____

11a. Munayamba mwagonanapo ndi wina?

a. Inde

b. Ayi (Skip to 13)

11b. Munali ndi zaka zingati pamene munagonana koyamba? _____

12a. Munayamba mwagwiritsapo ntchito chithandizo chokhudza moyo wanu wa uchembere kuchipatala kuno?

a. Inde

b. Ayi

12b. Ngati yankho lanu ndi inde, ndi liti pamene munadzalandira chithandizo chokhudza moyo wanu wauchembere liti?

a. Usanagonane koyamba

b. Utagonana koyamba

12c. Munaladira chithandizo chotani chokhudza uchembere wabwino?

a. Zolera

b. Kondomu

c. Zina (zitchuleni) _____

12d. Ngati munayamba kupita kuchipatala kukalandira chithandizo cha uchembere wabwino mutayamba kale zogonana, nchifukwa ninji?

a. Umbuli/kusazindikira

b. Kusowa kwa chithandizo kuchipatalako

c. Panalibe wondilimbikitsa

d. Kuopa kusalidwa ndi anthu

e. Kuopa makolo

f. Zifukwa zina (zitchuleni) _____

13. Munayamba mwakhala ndi mwana

a. Inde

b. Ayi

ZOKHUZA CHISAMALIRO CHA KUCHIPATALA

14. Nchifukwa ninji munabwera kuchipatala chino lero?

a. Kudzalandira uphungu wakulera

b. Kudzatenga njira zakulera

c. Kudzayedzetsa magazi pofufuza matenda opatsirana pogonana

d. Kudzayedzetsa magazi kuti ndidziwe ngati ndi ndi HIV

e. Kudzalandira chithandizo cha matenda opatsirana pogonana

g. Kudzalandira chithandizo chokhudzana ndi kutaya pakati

h. Kudzayedzetsa ngati ndiri ndi pakati

i. Kudzakwera sikelo ya amayi oyembekedzera

j. Kudzalandira uphungu wa kadyedwe koyenera

k.Kudzalandira uphungu okhudza achinyamata pa nkhani yogonana asanalaowe m'mbanja

l. Kudzafunsa za chithandizo pamene sakubereka

15a. Munali nawo mwayi wothandizidwa ndi aphungu kapena wopereka chithandizo?

a. Inde

b. Ayi

15b. Ngati yankho lanu mu funso 15a ndi inde, munathandizidwa bwanji?

_____

15c. Pankhani yomwe munapitira kuchipatala, munaona kuti opereka chithandizo anakuthandizana motani?

a. Bwino kwambiri
b. Bwino
c. Sanandithandize bwino
d. Sanandithandize komwe

16a. Kodi munakhutitsidwa ndi chithandizo munalandiracho?

a. Inde
b. No

16b. Perekani zifukwa pa yankho lanu la mu funso 16a.

_____
_____ 17.

Munapyola ndondemeko zotani musanaonanae ndi opereka chithandizo chanu?

Kodi munayamba ndi

a. Kukalembetsa dzina lanu
b. Kumvera uphungu wa zaumoyo?
c. Zina (zitchuleni) _____

18. Munatenga nthawi yaitali bwanji kuchokera pamene munafika pa chipatala kufikira pamene munawonana ndi omwe ankuthandizani?

a. Mphindi khumi ndi zisanu (15)
b. Mphindi makumi atatu (30)
c. Ola limodzi
d. Kupyola ola limodzi

19. Mukuona ngati nthawi yomwe munadikirayi inali yokwanira kapena ayi?

a. Sindinadikire
b. Inali yokwanira/yaifupi
c. Nthawi inatalika kwambiri
d. Sindikudziwa

20a. Kodi panayenera kuti mupangane za tsiku loti mudzabwere kuchipatala kuti mudzalandire chithandizo?

a. Inde
b. Ayi

20b. Ngati inde, panakutengerani nthawi yaitali bwanji kuti mufike tsiku loti mudzalandire chithandizocho

a. Patapita maola angapo
b. Patatha tsiku
c. Patatha masiku angapo
d. Patatha sabata imodzi
e. Patatha masabata angapo

20c. Kodi zimenezi munasangalala nazo?

A. Inde
b. Ayi

20d. Kodi mudakakonda mutakhala nthawi yotalika bwanjimukuyembekedzera kuti mukakomane ndi phungu kapena dokotala?

a. Patapita mphindi zingapo
b. Patapita maola angapo
c. Tsiku limodzi
d. Masiku angapo
e. Kupyola sabata imodzi
f. Osadikira
g. Nthawi ina (Tchulani) _____

20e. Kodi kupanga mgwirizano wa tsiku loti mudzalandire chithandizochi kunakuchedwetsani kuti mukumane ndi dokotala?

a. Inde

b. Ayi

20f. Ngati yankho lanu pa 25e ndi inde, munatsatira njira zotani kuti mupewe kapena kuchepetsa vuto lanu musanaonanae ndi dokotala?

_____

_____

21. Munatenga nthawi yaitali bwanji kukambirana ndi dphungu kapena dokotala? (Yerekezani) _____ (***Minutes***)

22. Kodi mukuona kuti nthawi yomwe munaonana ndi dokotala inali yokwanira.?
    a. Inali nthawi yochepa
    b. Inali nthawi yaitali
    c. Inali nthawi yokwanira
    d. Sindikudziwa
23. Kodi dokotala yemwe anakuthandizana anali
    a. Mwamuna
    b. Mkazi
24. Kodi mukuona kuti mmene anakuthandizirani kulandira chithandizo cha uchembere wanu zinatengera kuti anali wamkazi kapena wamwamuna?
    a. Inde
    b. Ayi
25. Ngati yankho lanu ku funso 24 ndi inde, ndimunjira yanji?

_____

_____

26. Kodi amene anakuthandizana anali
    a. Dokotala
    b. Namwino/mzamba
    c. Phungu
    d. Mlangizi wa zaumoyo
    e. Anthu ena (Atchuleni) _____
    f. Sindikudziwa
27. Kodi amene anakuthandizanayo anakupatsani moni wansangala?
    a. Inde
    b. Ayi
28. Fotokozani chifukwa chomwe mwayankhira chomwecho mu funso 26.

_____

_____

29. Kodi amene anakuthandiza anakufunsani chifukwa chomwe munapitira kuchipatala?
    a. Inde
    b. Ayi
30. Kodi wokuthandizaniyo/dokotala anailandira bwanji nkhaniyo (anaonetsa nkhope yotani/anayankhula zotani/anachita chiani?

_____

_____

31. Kodi inu munamva bwanji ndi momwe anachitira mu funso 30? Nanga ndi chifukwa chiani munamva choncho?

_____

32. Kodi inu mwapita ku chipatala chimenechi kangati?
    a. Kamodzi
    b. Kopitirira kamodzi
    c. Kopitirira katatu
    d. Nthawi ina (Tchulani kutalika kwake) _____

33a. Kodi mungadzabwereko kuchipatalachi?
    a. Inde
    b. Ayi

33b. Nchifukwa chiani ungachite momwe wayankhira m'funso lamwambali?

_____

34. Kodi munakambiranapo mwa mitu yomwe ili apayi. (Chongani zonse zoyenera)
    a. Mbiri yanu yogonana
    b. Momwe mukukhalira/kuchitira pankhani yogonana panopa
    c. Momwe ubwenzi wanu ukuyendera
    d. Zokhudza zolera – kale kapena panopa
    e. Njira zopewera matenda opatsirana pogonana ndinso kachilombo ka HIV.

35a. Kodi mukuona kuti opereka chithandizowo zimawakhudza zomwe mumafotokoza?
    a. Inde
    b. Ayi

35b. Nanga inuyo munali ndi mitu ina yokhudza uchemebere yomwe mumafuna kukambirana ndi a dokotala koma simunathe kutero?
    a. Inde
    b. Ayi

35c. Ngati yankho lanu mu funso 36a ndi inde, inali mitu iti? _____

35d. Ndi chifukwa chiani simunathe kukambirana?

_____

36a. Kodi adokotala anafunsapo mafunso okhudzana ndi iweyo?
    a. Inde
    b. Ayi

36b. Ngati yankho lanu mu 36a ndi inde, anafunsa mafunso anji?

_____

_____

37.Kodi opereka chisamaliro kuchipatala anakufotokozerani mwatsatanetsatane mochuluka bwanjipa mitu iyi?

Kiyi: 0 = palibe 1= ochepa 2 = ochulukirapo 3 = zambiri

i. Zanjira zolera _____
ii. Zamatenda a HIV/AIDS _____
iii. Za matenda ena opatsirana pogonana _____

38. Kodi opereka chisamaliro anakufunsani ngati mukudziwa kalikonse asanayambe kupereka malangizo?
    a. Inde
    b. Ayi
    c. Sindikudziwa

39.Kodi opereka chisamaliro anagwiritsa ntchito zipangizo monga izi pophunzitsa?

Kiyi: 1 =Inde 2= Ayi 3 = Sindikudziwa

    a. Mapositala ___
    b. Zojambula _____
    c. Mabukhu ang'onoang'ono ____
    d. Kanema_____
    e. Zidole _____

40a. Kodi opereka chisamaliroyop anapereka maganizo ake pa zomwe mungachita pofuna kuthetsa vuto lomwe munapitira?
    a. Inde
    b. Ayi

40b. Ngati yankho lanu mu funso 40a ndi inde, anpereka maganizo otani okhudza vuto lanu?

_____

_____

41a. Kodi inuyo munatenga nawo mbali pa zachisamaliro kapen a chithandizo chomwe munalandira?

a. Inde
b. Ayi

41b. Nanga munatengapo mbali yotanipa chithandizo chanu cha chipatala?

_____

42. Kodi opereka chithandizo ankufunsani ngati munali ndi mafunso?
a. Inde
b. Ayi

43. Kodi opereka chithandizo amayankha mafunso anu moyenera?
a. Inde
b. Ayi

44a. Kodi munali omasuka kuwafunsa mafunso opereka chisamalirowo?
a. Inde
b. Ayi

44b. Ngati ayi , nchifukwa chiani?

_____

45. Kodi uthenga kapena malangizo amene anaperekedwa ku chipatala anali omveka bwino?
a. Inde
b. Ayi

46a. Panali zina zomwe munalangizidwa koma sidzimamveka bwino?
a. Inde
b. Ayi

46b. Ngati yankho lanu ndi inde, ndi chiani chomwe simunamvetse, nanga nchifukwa chiani?

_____

47a. Kodi inu munasonyeza kwa opereka chithandizoyo kuti simunamvetse?
a. Inde
b. Ayi

47b. Ngati yankho lanu ndi inde, opereka chithandizo anakuthandizani bwanji?

_____

47c. Kodi munakhutitsidwa ndi momwe anakuthandizirani pamene munafunsa mafunso?
a. Inde
b. Ayi

48. Kodi amene munalankhula naye anafufuza ngati munamvetsetsa zomwe ankulangizanizo?
a. Inde
b. Ayi

49a. Kodi mukuona kuti munali ndi nthawi yokwanira yokambirana ndi amene amapereka chithandizo ndi malangizoyo?
a. Inde
b. Ayi

49b. Ngati ayi, nchifukwa chiani?

_____

50a. Kodi amene amapereka chithandizo ndi malangizoyo analankhula zina zili zonse zomwe zikanakukhumudwitsani?
a. Inde
b. Ayi

50b. Ngati anayankhulapo kena kake, adayankhulapo zotani?

_____

51a. Kodi amene amapereka chisamaliroyo analankhula kena konse kamene kanaonetsa kuti sanavomereze zina zimene munalankhula?

a. Inde
b. Ayi

51b. Ngati inde, analankhula ztani zimene sizinakusangalatseni?

_____

52. Ngati yankho la funso nambala 15a ndi ayi, panali zifukwa zotani?

a. Chipatala chinali chotseka
b. Mphungu panalibe pachipatala
c. Panalibe chipangano chokumana ndi mphunguyo
d. Mphungu ankana kuonana nanu
e. Zifukwa zina (Zitchuleni) _____

53. Ngati simunathe kukumana ndi mphungu yo kapena opereka chisamaliroyo, munapatsidwa tsiku lina loti mudzabwere kuti mudzalandire chithandizo?

a. Inde
b. Ayi

MALO OPEREKERA CHITHANDIZO

54a. Kodi amene amapereka chithandizo kuphatikizapo ogwira ntchito ena pa chipatalapo , amaoneka moti kubwera kwako amamasangalala nako kapena ayi?

a. Inde
b. Ayi

54b. Perekani zifukwa zimene mukuganizira poyankha funso 54a.

_____
_____

55a. Kodi sipamakhala kusiyana pa kalandilidwe ka anyamata ndi atsikana pa chipatalapo?

a. Inde
b. Ayi

LANGIZO KWA OFUNSA: FUNSANI FUNSO 55b KWA ANYAMATA OKHA

55b. Pamene munali mu chipatalamu, munakhalako ndi maganizo oti chipatalachi chimakondera kwa anthu a a kazi?

a. Inde
b. Ayi

55c. Ngati yankho lanu mu 55b ndi inde, zifukwa zake ndi ziti?

_____

56a. Ngati wopereka chithandizo anali wamkazi/mamuna (funsani malinga kuti ndi nyamata kapena mtsikana), munali osamasuka pokumana ndi dokotala?

a. Inde
b. Ayi

56b. Ngati yankho lanu ndi inde, chifukwa ninji?

_____

57a. Kodi nthawi kapena tsiku lomwe mwabwerera kuchipatala ino ndi yabwino kwa iwe?

a. Inde
b. Ayi

57b. Ngati nthawiyi siyabwino kwa iwe, chifukwa ninji?

_____

57c. Pali nthawi kapena tsiku lomwe ukuganiza kuti lingakhale labwino kuti uzibwera ku chipatala kuzapeza chithandizo cha uchembere?

a. Inde
b. Ayi

57d. Ngati yankho lako mu 57c ndi inde, nthawi kapena tsiku lake labwino lingakhale liti? _____

58a. Kodi alipo ena amamva nao zokambirana zanu ndi opereka chithandizo?
   a. Inde
   b. Ayi
   c. Sindikudziwa
58b. Ngati yankho lanu mu 58a ndi inde, chifukwa chain mukuganiza choncho?
   _____
59a. Chilipo chinthu china chomwe chinakutsokonezani pomwe mumakambirana ndi opereka chithandizo?
   a. Inde
   b. Ayi
59b. Ngati yankho lanu mu 59a ndi inde, ndi zinthu ziti?
   _____
60a.Kodi zokambirana zanu kapena chithandizo chanu amakupatsirana/kukumanirana m'chipinda momwe munalimo awiri nokha basi?
   a. Inde
   b. Ayi
60b. Ngati yankho lanu mu 60a ndi inde, chipinda chake chinali chotani? (Fotokozani mamangidwe ndi maonekedwe ake)
   _____
61a. Mukuona kuti chipinda chomwe munakumanira munali mwa chinsinsi?
   a. Inde
   b. Ayi
61b. Chifukwa ninji mukuganiza choncho?
   _____

62a. Mukukhulupira kuti zinthu zomwer mwamuudza opereka chithandizo sawaudzanso anthu ena?
   a. Inde
   b. Ayi
62b. Ngati yankho lanu mu 62a ndi ayi, chifukwa chiani mukuganiza choncho?
_____
63a. Kodi mukuganiza kuti anthu ena ogwira ntchito m'chipatala omwe mwakumana nao azatha kusunga chinsinsi chanu?
   a. Inde
   b. Ayi
63b. Chifukwa chiani mukuganiza choncho?
   _____
63c. Kodi anthu ena kapena ogwira ntchito pa chipatalapo adayankhulapo zinthu zomwe sizinakusangalatseni?
   a. Inde
   b. Ayi
63d. Mau ake anali otani? _____
64. Kodi opereka chithandizo anfuna kuti mukhale ndi zinthu zili munsimu kuti akuthandizeni?
   a. Chilolezo chochokera kwa makolo
   b. Chilolezo chochokera kwa bwenzi lako logonana nalo
   c. Anakuudzani kuti mwachepa kuti mulandire chithandizo
   d. Kuyedzedwa magazi asanakupatseni njira zolera
   e. Kukuyedzani m'thupi asanakupatseni njira zolera
   f. Mugwirizane tsiku loti mudzabwere musanalandire chithandizo chilichonse
65. Kodi opereka chithandizo anakuudzani kuti mudzabwerenso ku chipatala?
   a. Inde
   b. Ayi
66. Munagwirizana tsiku loti mudzabwerenso ku chipatalako?

a. Inde
b. Ayi

67a. Panali zinthu zina zimene zikanatha kukulepheretsani kulandira chithandizo?
a. Yes
b. Ayi

67b. Ngati yankho lanu mu 67a ndi inde, zinthu zake ndi ziti? (Fufuzani za mtengo, kupezeka kwa chithandizo, kutalika kwa chipatala)

_____

68a. Kodi inuyo mukuganiza kuti chipatalachi ndi chabwino kwa achinyamata?
a. Ndi chabwino
b. Sichabwino

68b. Chifukwa chiani (Fufuzani za malo oyembekedzera ndi malo ena onse konse wachinyamata anapitako, khalidwe la ogwira ntchito, kulandiridwa kwanu, ndondomeko mumatsata pofuna kulandira chithandizo)

_____

_____

69. Kodi m'zipinda mwa chipatalachi munali zinthu zomwe zinali ndi uthenga eg. mapositala omata pakhoma etc.
a. Inde
b. Ayi

70. Kodi zinthuzo/mapositalawo anatenga uthenga wokhudzana ndi chiani?
a. Zapakati
b. Matenda opatsirana pogonana
c. Za HIV/AIDS
d. Za kulera
e. Za kusamalira amayi omwe abereka
f. Za zokudya
g. Zina (Zitchuleni) _____

71. Kodi panali mapositala a uthenga ena omwe amapereka uthenga kwa achinyamata?
a. Inde
b. Ayi

72. Ngati yankho lanu mu funso 71 ndi inde, mapositalawo anali ndi uthenga wotani?

_____

73. Kodi mukuganiza kuti pachipatala pano pakufunika chiani kuti chizitha kuitanira achinyamata ambiri kuti adzagwiritse zithandizo za uchembere?

_____

74a. Kodi mungamualngize mzanu kuti adzakumane ndi dotolo yemwe munakomana naye inuyo?
a. Inde
b. Ayi

74b. Chifukwa ninji mungamulangize mzanu chomwecho?

_____

75. Pali chinthu china chilichonse chomwe mungafuna kuonjedzerapo chokhudzana ndi ulendo wanu wa lero wa ku chipatala chino?

_____

Zikomo kwambiri chifukwa cholera kuti tikambirane!

Annex 15A **: SURVEY QUESTIONNAIRE – English**

Cluster Number	
Village Name	
Household Number	
Interviewer name	
Interviewer Number	

Date of Interview	Day	Month	Year
Date of Edit	Day	Month	Year
Name of Supervisor			

Health Zone
ID of Respondent

We would like to ask you some questions about the reproductive health and well being of youth in your community and some of the factors and community practices that may affect it. Some of the questions are personal, but the answers you give will be kept confidential and will not be shown to anyone. They will only assist us in learning more about the behavior, beliefs and practices of young people.

Do I have your permission to continue?

1 = YES (Continue to next page.)

2 = NO (End the interview.)

Time Start: _____

Time End: _____

INSTRUCTIONS

1. BOLD TEXT IN CAPITALS IS AN INSTRUCTION TO THE INTERVIEWER

2. DO NOT READ LETTERED RESPONSE TO RESPONDENT

BACKGROUND INFORMATION

First, I want to ask you some questions about your background.

	PRECODE
(DO NOT ASK THIS QUESTION – simply provide answer) Sex of the respondent 1. Female 2. Male	1. _____
How old were you on your last birthday? ***RECORD AGE IN YEARS*** _____ 98. Don't know	2. _____
When were you born? (DD/MM/YY) Date: _____/_____/_____ 98. Don't know	3. _____
Have you ever attended school? 1. Yes 2. No ⟶ ***SKIP TO Q8***	4. _____
Are you currently attending school? 1. Yes ⟶ ***SKIP TO Q7*** 2. No	5. _____
Why are you not currently attending school? a. Already completed studies b. Got married c. Quit due to pregnancy d. Have to provide child care e. Family problems f. One or both parents have died g. Other (specify):_____	6. _____
What is the highest level of school you have completed? a. Primary (std 1-8) b. Secondary (Form 1-4) c. Technical/vocational school d. University/college e. Post-university/graduate school f. Don't know	7. _____
Have you ever had a boyfriend/girlfriend? Yes No ***SKIP TO Q14***	8. _____
Do you currently have a boyfriend/girlfriend? Yes No	9. _____

How old were you when you first had a boyfriend/girlfriend? 1. Age: _____ years old 98. Don't know/don't remember	10. _____
Have you ever been married? Yes No ***SKIP TO Q14***	11. _____
How old were you when you got married? 1. Age: _____ years old 98. Don't know/don't remember	12. _____
Are you currently: (**If married, go to the end of the questionnaire)** a. Married, living with spouse b. Married, spouse lives elsewhere c. Not married, but living with a partner d. Not married e. Divorced/separated f. Widowed	13. _____

Now I'm going to ask you some questions about HIV/AIDS and reproductive health. Some of the questions are person, but please be assured that your answers will be kept confidential and will not be shown to anyone.

HIV/AIDS and Reproductive Health

			PRECODE
Have you ever talked with one or both of your parents or an adult family member about:			14.
(***TICK ALL ANSWERS. MULTIPLE ANSWERS POSSIBLE.)***	***Yes***	***No***	Yes = 1, No=2
1. The female menstrual cycle			a. _____
2. Sexual and/romantic relationships			b. _____
3. How pregnancy occurs			c. _____
4. Sexually transmitted infections			d. _____
5. How to say no to sex			e. _____
6. Contraceptive methods			f. _____
7. How to prevent HIV			g. _____
8. Using safe sex practices			h. _____
Who is your primary source of information about RH relationship information? a. Friend b. Boyfriend/girlfriend c. Teacher d. Mother e. Father f. Both parents g. Initiator h. Aunt i. Uncle j. Sister/brother k. Other (***SPECIFY):*** _____			15. _____

What is your preferred source of information for reproductive health and HIV/AIDS a. Friend b. Boyfriend/girlfriend c. Teacher d. Mother e. Father f. Both parents g. Health worker h. Initiator i. Aunt j. Uncle k. Sister/brother l. Other (***SPECIFY):*** _____			16. _____
			PRECODE
Who do you trust most as a source of information on reproductive health? a. Friend b. Boyfriend/girlfriend c. Teacher d. Mother e. Father f. Both parents g. Initiator h. Aunt i. Uncle j. Sister/brother k. Other (***SPECIFY):*** _____			17. _____
Have you ever heard of HIV/AIDS? 1. Yes 2. No ⟶ *SKIP TO Q24*			18. _____
From which source of information did you hear of HIV/AIDS?			19.
(***TICK ALL ANSWERS. MULTIPLE ANSWERS POSSIBLE.)***	***Yes***	***No***	Yes = 1, No=2
a. Radio			a. _____
b. Newspaper			b. _____
c. Health worker			c. _____
d. Mosque			d. _____
e. Church			e. _____
f. School			f. _____
g. Adult community group			g. _____
h. Youth group			h. _____
i. Friends			i. _____
j. Relatives			j. _____
k. Posters/books/pamphlets			k. _____
l. None			l. _____
m. Other (***SPECIFY):*** _____			m. _____
How can HIV/AIDS be prevented?			20.
(***TICK ALL ANSWERS. MULTIPLE ANSWERS POSSIBLE.)***	***Yes***	***No***	Yes = 1, No=2
a. Abstain from sex			a. _____
b. Use condoms			b. _____
c. Avoid multiple sex partners			c. _____

d. Stay in a mutually monogamous relationship			d. _____
e. Avoid sex with prostitutes			e. _____
f. Avoid blood transfusions			f. _____
g. Avoid injections			g. _____
h. Avoid sharing razor blades			h. _____
i. Avoid sharing toothbrushes			i. _____
j. Use new or sterilized syringes or needles			j. _____
k. Other (***SPECIFY):*** _____			k. _____
l. Other (***SPECIFY):*** _____			l. _____
m. Don't know			m. _____

				PRECODE
How can HIV be transmitted?				21.
	YES	*No*	DK	Yes = 1, No=2, DK = 98
1. Kissing				a. _____
2. Sexual intercourse				b. _____
3. Sharing kitchen utensils				c. _____
4. Mother to child				d. _____
5. Blood transfusion				e. _____
6. Mosquito bites				f. _____
7. Needles/blades				g. _____
8. Breast feeding				h. _____
9. Sharing clothes				i. _____

Since you have heard of AIDS have you changed your behavior? 1. Yes *2.* No ⟶ *SKIP TO Q24* 98 Don't Know ⟶ *SKIP TO Q2*	22. _____

What did you do to change your behavior?			23.
(***TICK ALL ANSWERS. MULTIPLE ANSWERS POSSIBLE.)***	***Yes***	***No***	Yes = 1, No=2
a. Didn't start sex			a. _____
b. Quit sex			b. _____
c. Started using a condom			c. _____
d. Restricted sex to one partner			d. _____
e. Reduced number of partners			e. _____
f. Avoid sex with prostitutes			f. _____
g. Stopped injections			g. _____
h. Asked spouse to be faithful			h. _____
i. Asked girlfriend/boyfriend to be faithful			i. _____
j. Waiting longer periods between having sex			j. _____
k. Other (***SPECIFY):*** _____			k. _____

How many of your friends do think have had sexual intercourse (penis in vagina) 1. A few 2. About half 3. Most 98. Don't know	24. _____

Have you had sexual intercourse? 1. Yes 2. No ***GO TO Q28***	25. _____
At what age did you have your first sexual intercourse? ***RECORD AGE IN YEARS*** _____ 98. Don't know/don't remember	26. _____
	PRECODE
Have you had sexual intercourse in the last six months? 1. Yes 2. No 98. Don't know/don't remember	27. _____
Do you have a regular boyfriend/girlfriend? 1. Yes 2. No ——————→ *SKIP TO Q36*	28. _____
How long have you been with him/her? 1. Less than one month 2. 2-3 months 3. 3-6 months 4. 6- 12 months 5. Over a year	29. _____
How old is your boyfriend/girlfriend? ***RECORD AGE IN YEARS*** _____ 98. Don't know	30. _____
Have you ever had sex with your boyfriend/girlfriend? 1. Yes 2. No	31. _____
Could you talk about sex with your boyfriend/girlfriend? 1. Yes 2. No 98. Don't know	32. _____
Could you tell your boyfriend/girlfriend not to touch you sexually? 1. Yes 2. No 98. Don't know	34. _____

	PRECODE
Could you tell your boyfriend/girlfriend that you don't want to have sex with them? 1. Yes 2. No 98. Don't know	35. _____
Could you discuss abstinence with your girlfriend/boyfriend? 1. Yes 2. No 98. Don't know	36. _____
Would you abstain from sex? 1. Yes 2. No 98. Don't know	37. _____
How many boyfriends/girlfriends have you ever had? 1. Same boyfriend/girlfriend → *SKIP TO Q40* 2. 2-3 3. 4-6 4. 6-9 5. 10+	38. _____
Have you ever had sex with any of your other boyfriends/girlfriends? 1. Yes 2. No	39. _____
Have you ever had sex with anyone older than yourself? 1. Yes 2. No ***SKIP TO Q42*** 98. Don't know ***SKIP TO Q42***	40. _____
How many years older than you was that person? ***RECORD AGE IN YEARS_____*** *(IF LESS THAN ONE YEAR, RECORD AS 0)*	41. _____
Has anyone ever given you a gift or favor for having sex? 1. Yes 2. No	42. _____
	PRECODE

Has anyone ever given you money for having sex? 1. Yes 2. No			43. _____
Have you ever had sex against your will? 1. Yes 2. No			44. _____
Have you heard of condoms? 1. Yes **2. No ⟶ SKIP TO Q52**			45. _____
Do you think any of your friends are using condoms? 1. Yes 2. No 98. Don't know			46. _____
In the past six months, have you used a condom to protect yourself from STI/HIV/AIDS? 1. Yes 2. No ***SKIP TO Q49***			47. _____
Could you ask your boyfriend/girlfriend to use a condom? 1. Yes 2. No 98. Don't know			33. _____
How often do you use a condom? 1. Always 2. Sometimes 3. Never			48. _____
Why have you not used a condom in the past 6 months to protect yourself?			49.
(***TICK ALL ANSWERS. MULTIPLE ANSWERS POSSIBLE.)***	***Yes***	***No***	Yes = 1, No=2
a. Think it is not needed			a. _____
b. Afraid/shy to ask partner			b. _____
c. Not enjoyable			c. _____
d. Irritation			d. _____
e. Can burst			e. _____
f. Can get lost in the Vagina			f. _____
g. Other (***SPECIFY):*** _____			g. _____
h. Don't know			h. _____
i. Not sexually active			i. _____

If your partner approaches you for sex without a condom and you are not in favor can you refuse? 1. Yes 2. No 98. Don't know	50. _____
Ask those who never had sex before When do you intend to have sex? 1. Within 6 months 2. 6- 12 months 3. 1-2 year 4. More than 2 years 5. Never intend to have sex. 98. Don't know	51. _____

REPRODUCTIVE HEALTH

			PRECODE
Which methods of family planning do you know?			52.
(***TICK ALL ANSWERS. MULTIPLE ANSWERS POSSIBLE.)***	***Yes***	***No***	Yes = 1, No=2
a. Pill			a. _____
b. IUCD			b. _____
c. Injections			c. _____
d. Foam/Jelly			d. _____
e. Condom			e. _____
f. Female Sterilization			f. _____
g. Male Sterilization			g. _____
h. Natural Method			h. _____
i. Withdrawal			i. _____
j. Herbs			j. _____
k. Abstinence			k. _____
l. Exclusive Breast-feeding			l. _____
m. Other (***SPECIFY):*** _____			m. _____
Have you ever used any of these methods? 1. Yes 2. No ***SKIP TO Q58 FOR FEMALES, Q70 FOR MALES***			53. _____
Which methods have you used?			54.
(***TICK ALL ANSWERS. MULTIPLE ANSWERS POSSIBLE.)***	***Yes***	***No***	Yes = 1, No=2
a. Pill			a. _____
b. IUCD			b. _____
c. Injections			c. _____
d. Foam/Jelly			d. _____
e. Condom			e. _____
f. Female Sterilization			f. _____
g. Male Sterilization			g. _____
h. Natural Method			h. _____
i. Withdrawal			i. _____
j. Herbs			j. _____

k. Abstinence			k. _____
l. Exclusive Breast-feeding			l. _____
m. Other (***SPECIFY):*** _____			m. _____
Are you currently using a method? 1. Yes 2. No ——————→ *SKIP TO Q58*			55. _____
			PRECODE
Which method are you currently using?			56.
(***TICK ALL ANSWERS. MULTIPLE ANSWERS POSSIBLE.)***	***Yes***	***No***	Yes = 1, No=2
a. IUCD (Loop)			a. _____
b. Pill			b. _____
c. Injections			c. _____
d. Foam/Jelly			d. _____
e. Condom			e. _____
f. Female Sterilization			f. _____
g. Male Sterilization			g. _____
h. Natural Method			h. _____
i. Withdrawal			i. _____
j. Herbs			j. _____
k. Abstainence			k. _____
l. Exclusive Breast-feeding			l. _____
m. Other (***SPECIFY):*** _____			m. _____
Where do you get your methods?			57.
(***TICK ALL ANSWERS. MULTIPLE ANSWERS POSSIBLE.)***	***Yes***	***No***	Yes = 1, No=2
a. District hospital			a. _____
b. Health center			b. _____
c. Outreach clinic			c. _____
d. CBDA			d. _____
e. YCBDA			e. _____
f. BLM			f. _____
g. CHAM			g. _____
h. Private clinic			h. _____
i. TBA			i. _____
j. Grocery/Pharmacy			j. _____
k. Friends/Relatives			k. _____
l. Other (***SPECIFY):*** _____			l. _____

MATERNITY SERVICES (*FOR FEMALES ONLY*) 58 - 69

	PRECODE
Have you ever been pregnant? 1. Yes 2. No ***SKIP TO Q70***	58. _____
How many times have you been pregnant? _____ (***RECORD NUMBER)***	59. _____

At what age was your first pregnancy? _____ (***RECORD NUMBER)***	60. _____
In which month of your last pregnancy did you seek antenatal services? 1. 0-3 2. 4-6 3. 7-9 4. Never sought care **(*SKIP TO Q63)***	61. _____
Where did you get antenatal services? 1. District hospital 2. Health centre 3. Private clinic 4. TBA 5. Home 6. Other (***SPECIFY***) _____	62. _____
Where did you deliver? a. District hospital b. Health centre c. Private clinic d. TBA e. Home f. Other (***SPECIFY)*** _____	63. _____
Who attended your delivery? a. TBA b. Nurse c. Other hospital staff d. Relatives e. No one f. Other: (***SPECIFY***): _____	64. _____
How well were you treated by the attendant? 1. Very well 2. Well 3. Not well	65. _____
Did you receive post-natal care? 1. Yes 2. No ***SKIP TO Q68***	66. _____

Where did you receive post natal care? a. District hospital b. Health centre c. Private clinic d. TBA e. Home f. Other (***SPECIFY***) _____	67. _____
During your last pregnancy, did you receive family planning counseling (during antenatal and/or postnatal)? 1. Yes 2. No	68. _____
What kind of family support did you receive during your last pregnancy? _____ _____ _____	69. _____

Sexually Transmitted Infections

			PRECODE
Have you heard of sexually transmitted infections? 1. Yes 2. No ***SKIP TO Q82 (males) SKIP TO 85 females***			70. _____
From what sources of information? (***TICK ALL ANSWERS. MULTIPLE ANSWERS POSSIBLE.)***	***Yes***	***No***	71. Yes = 1, No=2
a. Radio			a. _____
b. Newspaper			b. _____
c. Health worker			c. _____
d. Mosque			d. _____
e. Church			e. _____
f. School			f. _____
g. Adult community group			g. _____
h. Youth group			h. _____
i. Friends			i. _____
j. Relatives			j. _____
k. Posters/books/pamphlets			k. _____
l. None			l. _____
m. Other (***SPECIFY):*** _____			m. _____
			PRECODE
Which sexually transmitted infections (STIs) do you know?			72.
(***TICK ALL ANSWERS. MULTIPLE ANSWERS POSSIBLE.)*** ***Probe more for signs and symptoms***	***Yes***	***No***	Yes = 1, No=2
a. Syphilis			a. _____

b. Gonorrhea			b. _____
c. Genital warts			c. _____
d. Chancroid			d. _____
e. Trichomoniasis			e. _____
f. Buboes			f. _____
g. Chlamydia			g. _____
h. Herpes Symplex			h. _____
i. Other_____ ***(SPECIFY)***			i. _____
j. Other_____ ***(SPECIFY)***			j . _____
In the past 12 months, have you had any of these Sexually Transmitted Infections? 1. Yes 2. No ***SKIP TO Q82 FOR MALES, Q85 FOR FEMALES***			73. _____
Which STIs did you have?			74.
(***TICK ALL ANSWERS. MULTIPLE ANSWERS POSSIBLE.)***	***Yes***	***No***	Yes = 1, No=2
a. Syphilis			a. _____
b. Gonorrhea			b. _____
c. Genital warts			c. _____
d. Chancroid			d. _____
e. Trichomoniasis			e. _____
f. Buboes			f. _____
g. Chlamydia			g. _____
h. Herpes symplex			h. _____
i. Other_____ ***(SPECIFY)***			g. _____
j. Other_____ ***(SPECIFY)***			h. _____
Did you seek treatment? Yes No ***SKIP TO 80***			75. _____
Where did you seek treatment?			76.
(***TICK ALL ANSWERS. MULTIPLE ANSWERS POSSIBLE.)***	***Yes***	***No***	Yes = 1, No=2
a. District hospital			a. _____
b. Health center			b. _____
c. Outreach clinic			c. _____
d. BLM			d. _____
e. Private clinic			e. _____
f. TBA			f. _____
g. Grocery/Pharmacy			g. _____
h. Friends/Relatives			h. _____
i. Self Treatment			i. _____
j. Other (***SPECIFY):*** _____			k. _____
			PRECODE

How well were you treated by the attendant? 1. Very well 2. Well 3. Not well	77. _____
Did the attendant counsel you on how to prevent future infections? 1. Yes **2.** No ——————→**SKIP TO 80**	78. _____

What did he/she say?			79.
(***TICK ALL ANSWERS. MULTIPLE ANSWERS POSSIBLE.)***	***Yes***	***No***	Yes = 1, No=2
a. Abstain from sex			a. _____
b. Use condoms			b. _____
c. Avoid multiple sex partners			c. _____
d. Other_____***(SPECIFY)***			d. _____
e. Other_____(***SPECIFY)***			e. _____
f. Other_____***(SPECIFY)***			f. _____

QUESTIONS 80– 82 ARE FOR MALES WHO NEVER HAD AN STI

	PRECODE
If you had an STI or any symptoms, did you inform your parents? 1. Yes 2. No	80. _____
If you had an STI or any of these symptoms, did you inform your partner(s)? 1. Yes 2. No	81. _____
Some males experience pain during urination. During the last 12 months have you noticed any pain when urinating? 1. Yes 2. No 3. Don't remember	82. _____
Some males sometimes have a discharge from the penis. During the last 12 months have you noticed any discharge from your penis? 1. Yes 2. No 3. Don't remember	83. _____

Some men experience sores in the genital area which are not due to any injury. During the last 12 months, have you noticed any sores in your genital area? 1. Yes 2. No 3. Don't remember	84. _____

MALES SKIP TO Q87. QUESTIONS 83-86 ARE FOR FEMALES ONLY

	PRECODE
During the last 12 months, have you had an abnormal vaginal discharge? 1. Yes 2. No 3. Don't remember	85. _____
During the last twelve months, have you had any itching or irritation in your vulvar area? 1. Yes 2. No 3. Don't remember	86. _____
During the last 12 months, have you had a sore in your vulvar area not due to an injury or pregnancy? 1. Yes 2. No 3. Don't remember	87. _____
During the last 12 months, have you had severe lower abdominal pain with fever not related to menstruation or pregnancy? 1. Yes 2. No 3. Don't remember	86. _____

Can you list all the ways to protect oneself from getting an STI?			89.
(***TICK ALL ANSWERS. MULTIPLE ANSWERS POSSIBLE.)***	***Yes***	***No***	Yes = 1, No=2
a. Abstain from sex			a. _____
b. Use condoms			b. _____
c. Avoid multiple sex partners			c. _____
d. Stay in a mutually monogamous relationship			d. _____
e. Use new or sterilised syringes or needles			e. _____
f. Others (Specify) _____			f. _____

Now I want to ask you some questions about services that may be available in your community.

	PRECODE

Have you ever heard about Youth friendly reproductive health services or programmes? Yes No			90. _____
Are you a member of a youth club? 1. Yes 2. No ***SKIP TO Q93*** 98. Don't know ***SKIP TO Q93***			91. _____
What is the name of the youth club? _____ (***NAME OF YOUTH CLUB***)			92. _____
Have you ever heard of a youth resource centre? Yes No ***SKIP TO Q101*** 98. Don't know ***SKIP TO Q101***			93. _____
Have you visited a youth resource center in the past six months? Yes No ***SKIP TO Q101*** 98. Don't know***SKIP TO Q101***			94. _____
What is the name of the youth resource center you visited the last time? _____ (***NAME OF YOUTH RESOURCE CENTER***)			95. _____
How did you hear about the youth resource center?			96.
(***TICK ALL ANSWERS. MULTIPLE ANSWERS POSSIBLE.)***	***Yes***	***No***	Yes = 1, No=2
a. Youth Zone Coordinators			a. _____
b. Radio			b. _____
c. Peer Educator			c. _____
d. TV			d. _____
e. Newspaper			e. _____
f. Relative			f. _____
g. Friend			g. _____
h. Teacher			h. _____
i. Newsletter			i. _____
j. Poster			j. _____
k. Pamphlet/brochure			k. _____
l. Religious leader			l. _____
m. YCBDA			m. _____
n. Open Day			n. _____
o. Sign on youth resource center			o. _____
p. Other (***SPECIFY***): _____ q. Don't know/Don't remember			p. _____ q. _____
What was your reason for visiting the resource center the last time?			97.
(***TICK ALL ANSWERS. MULTIPLE ANSWERS POSSIBLE.)***	***Yes***	***No***	Yes = 1, No=2
a. Meet friends			a. _____
b. Recreation activities			b. _____
c. Get RH information			c. _____
d. Share RH information			d. _____

e. Other (***SPECIFY):*** _____ f. Don't know/don't remember			e. _____ f. _____
Would you return to this youth resource center again? 1. Yes 2. No ***SKIP TO Q100*** 98. Don't know ***SKIP TO Q100***			98. _____
Why would you return to the youth resource center?			99.
(***TICK ALL ANSWERS. MULTIPLE ANSWERS POSSIBLE.)***	***Yes***	***No***	Yes = 1, No=2
a. Friendly/caring staff b. Place to talk with peer educators c. Convenient d. Had a nice experience e. For any other health problem f. Other (***SPECIFY***): _____			a. _____ b. _____ c. _____ d. _____ e. _____ f. _____
			PRECODE
Why would you not return to the youth resource center?			100.
(***TICK ALL ANSWERS. MULTIPLE ANSWERS POSSIBLE.)***	***Yes***	***No***	Yes = 1, No=2
a. Needed parent's permission b. Needed spouse's permission c. Unfriendly/rude staff d. Lack of privacy e. Embarrassed to go there			a. _____ b. _____ c. _____ d. _____ e. _____
f. Too far			f. _____
g. Other (specify): _____			g. _____
Have you ever heard of a peer educator? 1. Yes 2. No ***SKIP TO Q104*** 98. Don't know ***SKIP TO Q104***			101. _____
Have you met with a peer educator in the last 6 months? 1. Yes 2. No ***GO TO Q104*** 98. Don't know ***GO TO Q104***			102. _____
Where did you meet with a peer educator the last time? 1. School 2. Clinic 3. Youth Club 4. Youth Resource Center 5. Community 6. Market 7. Other (specify): _____ 98. Don't know			103. _____

104. Have you ever heard of a youth community-based distribution agent (YCBDA)? 1. Yes 2. No ***SKIP TO Q108*** 98. Don't know ***SKIP TO Q108***	104. _____
105. Have you met with a YCBDA in the last 6 months? 1. Yes 2. No ***SKIP TO Q109*** 98. Don't know ***SKIP TO Q109***	105. _____
106. Where did you meet with a YCBDA the last time? 1. School 2. Clinic 3. Youth club 4. Youth Resource Center 5. Community 6. Market 7. Other (specify): _____ 98. Don't know	106. _____

				PRECODE
107. Was the YCBDA: (READ EACH ITEM):				107.
	Yes	No	DK	Yes =1, No =2, DK = 98
1. Knowledgeable				1. _____
2. Friendly				2. _____
3. Interested in you				3. _____
4. Well-qualified				4. _____
5. A good communicator				5. _____
6. Respectful				6. _____
7. Polite				7. _____
8. Caring about your privacy/confidentiality				8. _____
9. Honest and direct				9. _____
10. A good listener				10. _____
11. Able to help you				11. _____

108. Have you visited a clinic for reproductive health services in the last six months? 1. Yes 2. No. ***GO TO END***	108. _____
109. What clinic did you visit? _____ (***NAME OF CLINIC***)	109. _____

110. What was your reason for visiting the clinic last time?			110.
(***TICK ALL ANSWERS. MULTIPLE ANSWERS POSSIBLE.)***	***Yes***	***No***	Yes = 1, No=2
a. Physical check up			a. _____
b. Treatment			b. _____
c. Family planning			c. _____
d. Counselling on HVI/AIDS			d. _____

e. Other (***SPECIFY***): _____			e. _____
111. Who did you talk to or see at the clinic the last time?			111.
(***TICK ALL ANSWERS. MULTIPLE ANSWERS POSSIBLE.)*** ***(Probe by asking, "What type of service provider?"***	***Yes***	***No***	Yes = 1, No=2
a. Doctor			a. _____
b. Nurse			b. _____
c. Health aide			c. _____
d. Peer educator/counselor			d. _____
e. Other (***SPECIFY):*** _____			e. _____
f. Don't know/don't remember			f. _____
			PRECODE
112. Was the [service provider] (***READ EACH ITEM***):			112.
	Yes	No	DK	Yes .=1, No =2, DK = 98
1. Knowledgeable				1. _____
2. Friendly				2. _____
3. Interested in you				3. _____
4. Well-qualified				4. _____
5. A good communicator				5. _____
6. Respectful				6. _____
7. Polite				7. _____
8. Caring about your privacy/confidentiality				8. _____
9. Honest and direct				9. _____
10. A good listener				10. _____
11. Able to help you				11. _____
113. Would you return to this clinic again? Yes No ***SKIP TO 115*** 98. Don't know***SKIP TO END***				113. _____
114. Why would you return to the clinic?				114.
	Yes	***No***		Yes = 1, No=2
1. Friendly/caring staff				1. _____
2. Short waiting time				2. _____
3. Youth corner				3. _____
4. Place to talk with peer educators				4. _____
5. Convenient				5. _____
6. Had a nice experience				6. _____
7. For any other health problem				7. _____
8. For pregnancy care				8. _____
9. For STI treatment				9. _____
10.Other (***SPECIFY***): _____				10. _____
115. Why would you not return to the clinic?				115.
(***TICK ALL ANSWERS. MULTIPLE ANSWERS POSSIBLE.)***	***Yes***	***No***		Yes = 1, No=2
1. Needed parent's permission				1. _____
2. Needed spouse's permission				2. _____
3. Unfriendly/rude staff				3. _____
4. Staff does not welcome/approve of young people				4. _____

5.	Lack of privacy			5. _____
6.	Embarrassed to go there			6. _____
7.	Long waiting time			7. _____
8.	Too expensive			8. _____
9.	Might be asked to bring partner			9. _____
10.	No drugs dispensed at clinic			10. _____
11.	Prefer to go to the traditional			11. _____
12.	No health problems			12. _____
13.	Too far			13. _____
14.	Prefer another clinic			14. _____
15.	Other (specify): _____			15. _____ _____

THANK THE PARTICIPANTS FOR THEIR TIME AND EFFORT

Annex 15B **: SURVEY QUESTIONNAIRE – Chichewa**

Cluster Number		Date of Interview	Day	Month	Year	Health Zone	
Village Name							
Household Number		Date of Edit	Day	Month	Year	ID of Respondent	
Interviewer name							
Interviewer Number		Name of Supervisor					

Timafuna tikufunseniko mafunso ena ndi ena okhuzana ndi uchembere ndi Umoyo wabwino wa achinyamata m'dela lanu komanso zovuta zina ndi machitidwe omwe angakhuzane ndi nkhaniyi. Mafunso ena ndi okhuzana ndi inuyo, koma mayankho omwe mutipatse adzasungidwa mwa chinsinsi ndipo sadzaonetsedwa kwa munthu wina aliyense. Adzangotithandiza ife kudziwako zambiri za makhalidwe, zikhulupiliro ndi zochita za achinyamata

Kodi ndili ololedwa kupitiliza?

1 = Inde (pitani patsamba lotsatilalo)

2 = Ayi (mapeto a mafunso)

Nthawi yoyambira: _____

Nthawi yotsilizira: _____

MALANGIZO

3. MALEMBO OWALITSIDWA AZILEMBO ZIKULUZIKULU NDI MALANGIZO KWA OFUNSA

4. MUSAMUWELENGERE OFUNSIDWAYO MAYANKHO OMWE ALEMBEDWA a, b, c, d, e, etc.

MBIRI YANU

Choyambilira ndafuna kudziwa nawo zambiri yanu

	PRECODE
1. (FUNSOLI LISAFUNSIDWE – MUNGOPEREKA YANKHO) Amene akufunsidwayo ndi 3. Wamkazi 4. Mwamuna	1. _____
2. Munali ndi zaka zingati pamene mumakumbukira tsiku lanu lobadwa posachedwapa? ***Zaka*** _____ 98. Sindikudziwa	2. _____
3. Munabadwa liti? (tsiku/mwezi/chaka) Deti: _____/_____/_____ 98. Sindikudziwa	3. _____
4. Mudapitapo ku sukulu? 3. Inde 4. Ayi → **SKIP TO Q8**	4. _____
5. Nanga panopa mumapita ku sukulu? 3. Inde → **SKIP TO Q7** 4. Ayi	5. _____
6. Ndi chifukwa chiyani panopa simupita ku sukulu? Ndinamaliza maphunziro anga Ndinalowa M'banja Ndinasiya chifukwa cha mimba Ndimayenera kuti ndilele mwana Mavuto a pakhomo Kholo kapena makolo onse anamwalira Zifukwa zina (fotokozani)_____	6. _____
7. Munapita patali bwanji ndi maphunziro anu Pulaimale (sitandade 1-8) Sekondale (Folomu 1-4) Ntchito zaumisili/zamanja Yunivesite/Ukachenjede Maphunziro owonjezera nditachoka ku Yunivesite/ukachenjede Sindikudziwa	7. _____
8. Munayamba mwakhalapo ndi chibwenzi? Inde Ayi ~~SKIP~~ **TO Q10**	8. _____
9. Panopa muli ndi chibwenzi? Inde Ayi	9. _____

10. Munali ndi zaka zingati pamene mudali ndi chibwenzi chanu choyambilira? 1. Zaka: _____ 98. Sindikudziwa/sindikudziwa	10. _____
	PRECODE
11. Munayamba mwakhalako pa banja? Inde Ayi ——— **SKIP TO Q14**	11. _____
12. Munali ndi zaka zingati pamene mumalowa m'banja? 1. zaka _____ 98. Sindikudziwa/ndaiwala	12. _____
13. Panopa ndinu wokwatira/wokwatiwa: - (**Ngati wokwatira/wa, pitani kumapeto a questionnaire**) Wokwatira/wokwatiwa, ndipo mumakhala ndi akazi/amuna anu Wokwatira/wokwatiwa, mkazi/mwamuna amakhalira kwina Wosakwatira/wosakwatiwa, koma mumakhala limodzi ndi wokondedwa wanu Wosakwatira/wosakwatiwa, Banja linatha/tinasiyana Wamasiye	13. _____

Tsopano ndikufunsaniko mafunso ena okhuzana ndi HIV/AIDS ndi a zauchembere wabwino. Ena mwamafunsowa ndi okhudzana ndi inu, koma ndikukutsimikizirani kuti mayankho anu adzasungidwa mwa chinsinsi komanso sadzaonetsedwa kwa wina aliyense.

HIV/AIDS NDI UCHEMBERE WABWINO

			PRECODE
14. Kodi unayamba wakambilanapo ndi kholo kapena makolo ako onse kapena ndi akulu ena alionse a mtundu wako za:			14.
(***CHONGANI MAYANKHO ONSE MAYANKHO ANGAPO NDI OLOLEDWA.)***	***Yes***	***No***	Yes = 1, No=2
1. Kusamba kwa amai mwezi ndi mwezi			1. ____
2. Ubwenzi wongogonana kapena ubwenzi chabe			2. ____
3. Mmene munthu angatengere mimba			3. ____
4. Matenda opatsilana pogonana			4. ____
5. Kukana kugonana ndi munthu			5. ____
6. Njira zolelera			6. ____
7. Mmene tingapewere HIV/AIDS			7. ____
8. Njira zozitetezera pogonana			8. ____

15. Ndani amene amakuuzani za uchembere wabwino mopanda kukaika? Nzanga Chibwenzi Aphunzitsi Amai anga Bambo anga Makolo onse Nankungwi Azakhali Amalume Peer educator YCBDA Mlongo/m'bale wanga A zaumoyo Ena (tchulani***):*** _____	15. _____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____
	PRECODE

16. Nanga ndi ndani amene mungakonde kuti azikuuzani za uchembere wabwino komanso HIV/AIDS a. Nzanga b. Chibwenzi c. Aphunzitsi d. Amai anga e. Bambo anga f. Makolo onse g. Nthumwi ya zaumoyo h. Nankungwi i. Azakhali j. Amalume k. Peer educator l. YCBDA m. Mlongo/m'bale wanga n. Ena (tchulani***):*** _____			16. _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
17. Ndi munthu uti amene ungamukhulupilire atamakuuza za uchembere wabwino? a. Nzanga b. Chibwenzi c. Aphunzitsi d. Amai anga e. Bambo anga f. Makolo onse g. Nankungwi h. Azakhali i. Amalume j. Mlongo/m'bale wanga k. A zaumoyo l. Peer educator m. YCBDA n. Ena (tchulani***):*** _____			17. _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
18. Kodi munamvako za HIV/AIDS? 3. Inde 4. Ayi ⟶ **SKIP TO Q24**			18. _____
19. Unazimva kuchokera kuti?			19.
(***CHONGANI MAYANKHO ONSE. MAYANKHO ANGAPO NDI OLOLEDWA.)***	***Yes***	***No***	Yes = 1, No=2
n. Pawailesi			a. _____
o. Munyuzipepala			b. _____
p. Kwa nthumwi yazaumoyo			c. _____
q. Ku mzikiti			d. _____
r. Ku tchalitchi			e. _____
s. Kusukulu			f. _____
t. Gulu la amai ndi abambo			g. _____
u. Gulu laachinyamata			h. _____
v. Anzanga			i. _____
w. Achibale			j. _____
x. Zokhomakhoma/mabuku/zolembalemba			k. _____
y. Palibe			l. _____

z. Njira zina (zitchuleni)*:* _____			m. _____
20. Kodi tingapewe bwanji HIV/AIDS?			20.
(***CHONGANI MAYANKHO ONSE – MAYANKHO ANGAPO NDI OLOLEDWA.)***	***Yes***	***No***	Yes = 1, No=2
n. Kusiya kugonana			a. _____
o. Pogwiritsa ntchito makondomu			b. _____
p. Kupewa kugonana ndi anthu/abwenzi ambiri			c. _____
q. Kukhala ndi okondedwa mmodzi			d. _____
r. Kupewa kugonana ndi mahule			e. _____
s. Kupewa kulandila magazi			f. _____
t. Kupewa kubaidwa jakiseni			g. _____
u. Osabwelekana malezala			h. _____
v. Osabwerekana miswachi			i. _____
w. Pogwiritsa ntchito zida zatsopano kepna jakisoni/zowiritsa			j. _____
x. Njira ina (fotokozani*):* _____			k. _____
y. Njira ina (fotokozani*):* _____			l. _____
z. Sindikudziwa			m. _____
21. Kodi HIV/AIDS ingafale mu njira izi: -			21.

	YES	*No*	DK	Yes = 1, No=2, DK = 98
1. Kupsopsonana				1. _____
2. Pogonana				2. _____
3. Pobwerekana ziwiya zophikira				3. _____
4. Mai wapakati kupatsira mwana odzabadwayo				4. _____
5. Popeleka kapena polandila magazi				5. _____
6. Kulumidwa ndi udzudzu				6. _____
7. Masingano/malezala				7. _____
8. Poyamwitsa mwana mkaka wa mmaele				8. _____
9. Pobwerekana zovala				9. _____

	PRECODE
22. Kodi mwasintha khalidwe lanu pomwe mudamva za HIV/AIDS? 3. Inde *4.* Ayi ⟶ **SKIP TO Q24** 98. Sindikudziwa ⟶ **SKIP TO Q24**	22. _____

23. Khalidwe lanu lasintha motani?			23.
(***CHONGANI MAYANKHO ONSE – MAYANKHO ANGAPO NDIOLOLEDWA)***	***Yes***	***No***	Yes = 1, No=2
l. Sindidayambe kugonana			a. _____
m. Ndidasiya kugonana			b. _____
n. Ndidayamba kugwiritsa ntchito makondomu			c. _____
o. Ndimagonana ndi bwenzi mmodzi yekha			d. _____
p. Ndidachepetsa chiwerengero cha anthu omwe ndimagonana nawo			e. _____
q. Ndikumapewa kugonana ndi mahule			f. _____

r. Ndidasiya kugwiritsa ntchito majakisoni			g. _____
s. Ndinakambirana ndi mamuna/mkazi wanga kuti azikhulupilika			h. _____
t. Ndinakambirana ndi bwenzi langa kuti adzikhulupilika			i. _____
u. Kukhala nthawi yaitali tisanagonane			j. _____
k. Njira zina (zitchuleni***):*** _____			k. _____
24. Ndi anzako angati amene ukukhulupilira kuti anayamba agonanapo. (mamuna ndi mkazi) 4. ochepa 5. mwina theka 6. ochuluka 98. sindikudziwa			24. _____
25. Kodi unayamba zogonana? 3. Inde 4. Ayi → **SKIP TO Q28** **Kumbukirani kufunsa funso nambala 50 kwa okhao ayankha funso nambala 25 kuti <u>AYI</u>**			25. _____
26. Unayamba kugonana uli ndi zaka zingati ?` ***Zaka*** _____ 98. sindikudziwa/ndaiwala			26. _____
27. Mumiyezi isanu ndi umodzi yapitayi wagonanapo ndi wina aliyense? i. Inde ii. Ayi 98. Sindikudziwa/ndaiwala			27. _____

	PRECODE
28. Kodi uli ndi chibwenzi chodalilika? a) Inde b) Ayi ——————→ **SKIP TO Q36**	28. _____
29. Nanga wakhala naye nthawi yaitali bwanji? 6. Sitinathe mwezi umodzi 7. Pakati pa miyezi iwiri ndi itatu 8. Pakati pa miyezi itatu ndi isanu ndi umodzi 9. Pakati pa miyezi isanu ndi umodzi ndi chaka 10. Kupitilira chaka chimodzi	29. _____
30. Kodi bwenzi lako liri ndi zaka zingati? (lembani zaka zokha) *Zaka* _____ 98. sindikudziwa	30. _____
31. Unayamba wagonanapo ndi bwenzi lakoli? 3. Inde 4. Ayi	31. _____

32. Ungathe kukambirana ndi bwenzi lako za kugonana? 3. Inde 4. Ayi 98. Sindikudziwa	32. _____
33. Ungathe kumuuza bwenzi lako kuti asamagwire thupi lako kuopa kuti ungakhale ndi chilakolako chofuna kugonana? 3. Inde 4. Ayi 98. Sindikudziwa	33. _____
34. Ungathe kumuuza bwenzi lako kuti sukufuna zogonana 3. Inde 4. Ayi 98. Sindikudziwa	34. _____
35. Ungathe kukambirana ndi bwenzi lako kuti mudziletse/musagonane kwa miyezi isanu ndi umodzi kapena kupitilira apa? 3. Inde 4. Ayi 98. Sindikudziwa	35. _____

	PRECODE
36. Kodi ungathe kusiya kugonana? 3. Inde 4. Ayi 98. Sindikudziwa	36. _____
Funsoli lifunsidwe kwa okhawo amene anayamba kale kugonana kupatulapo omwe ali pa banja 37. Kodi wakhalapo ndi zibwenzi zingati mmoyo mwako? 6. Chibwenzi chimodzi chomwecho ⟶ **SKIP TO Q39** 7. Pakati pa ziwiri ndi zitatu 8. Pakati pa zinayi ndi zisanu ndi chimodzi 9. Pakati pa zisanu ndi chimodzi ndi zisanu ndi zinayi 10. Zopitilira khumi	37. _____
38. Kodi unayamba wagonanapo ndi mmodzi mwa abwenzi akowa? 3. Inde 4. Ayi	38. _____
39. Unayamba wagonanapo ndi wina aliyense woposa zaka zako zakubadwa? 3. Inde 4. Ayi **SKIP TO Q42** 98. Sindikudziwa **SKIP TO Q42**	39. _____
40. Nanga iyeyu amakuposa ndi zaka zingati? ***Zaka*** _____ **(NGATI NDI ZOCHEPERA CHAKA CHIMODZI LEMBANI 0)**	40. _____
41. Kodi wina aliyense anayamba wakupatsako mphatso kapena kukuthokoza chifukwa chogonana naye? 3. Inde 4. Ayi	41. _____
42. Alipo amene anakupatsako ndalama chifukwa chogonana naye? 3. Inde 4. Ayi	42. _____
43. Udayamba wakakamizidwapo kugonana ndi wina aliyense usakufuna? 1. Inde 2. Ayi	43. _____

			PRECODE
44. Udamvapo zamakondomu? 3. Inde 4. Ayi ——————→ **SKIP TO Q52**			44. _____
45. Kodi ukuganiza kuti anzako ena amagwiritsa ntchito makondomu? 3. Inde 4. Ayi 98. Sindikudziwa			45. _____
Check response on Q27 46. Pa miyezi isanu ndi umodzi yapitayi, kodi udagwiritsako ntchito kondomu kuti udzitetezere ku matenda opatsilana pogonana - ST/HIV/AIDS? 3. Inde 4. Ayi ⟶ **SKIP TO Q49**			46. _____
47. Ungathe kuuza bwenzi lako kuti mugwiritse ntchito kondomu? 3. Inde 4. Ayi 98. Sindikudziwa			47. _____
48. Umagwiritsa ntchito kondomu motani? 4. Nthawi zones ——————→ **SKIP TO Q50** 5. Nthawi zina 6. Sitimagwiritsa ntchito			48. _____
49. Nchifukwa chiyani siudagwiritseko ntchito kondomu pa miyezi isanu ndi umodzi yapitayi?			49.
(***CHONGANI MAYANKHO ONSE, MAYANKHO ANGAPO NDI OLOLEDWA.)***	***Yes***	***No***	Yes = 1, No=2
j. Poganiza kuti siyofunika			a. _____
k. Ndimaopa/ndimachita manyazi			b. _____
l. Ndiyosasangalatsa			c. _____
m. Imayabwa			d. _____
n. Ikhonza kuphulika			e. _____
o. Ingasokonekere kumaliseche a mkazi			f. _____
p. Zifukwa zina (zitchuleni***):*** _____			g. _____
q. Siimakometsa kugonana			h. _____
50. Ngati chibwenzi chanu chitakupemphani kuti mugonane nacho popanda kondomu kodi ungakane? 1. Inde 2. Ayi 98. Sindikudziwa			50. _____

	PRECODE
Funsani kwa amene sanagonanepo chiyambire ndi anene ayankha funso nambala 25 51. Ukuganiza kuti udzayamba liti kugonana? Mkati mwa miyezi isanu ndi umodzi 6. Pakati pa miyezi isanu ndi umodzi ndi chaka 7. Pakati pa chaka chimodzi ndi zaka ziwiri 8. Kuposa zaka ziwiri 9. Sindikuganiza zogonana ndi aliyense. 10. Sindikudziwa	51. _____

UCHEMBERE WABWINO (ACHINYAMATA A ZAKA ZA PAKATI PA 11 NDI 24)

			PRECODE
52. Ndi njira ziti zolelera zimene umazidziwa?			52.
(***CHONGANI MAYANKHO ONSE – MAYANKHO ANGAPO NDI OLOLEDWA.)***	***Yes***	***No***	Yes = 1, No=2
n. Mapilisi			a. _____
o. Lupu			b. _____
p. Jakisoni			c. _____
q. Thovu			d. _____
r. Makondomu			e. _____
s. Kutseka kwa amai			f. _____
t. Kutseka kwa abambo			g. _____
u. Njira yachilengedwe			h. _____
v. Kuthira umuna pambali			i. _____
w. Zitsamba			j. _____
x. Kudziletsa			k. _____
y. Kuyamwitsa mwana mwakathithi			l. _____
z. Njira zina (zitchuleni)***:*** _____			m. _____
53. Kodi unayamba wagwiritsako ntchito njira zina mwa njira zolelerazi? 3. Inde 4. Ayi ⟶ **NGATI NDI MKAZI PITANI KU FUNSO LA Q58 NGATI NDI MWAMUNA PITANI KU FUNSO LA Q70**			53. _____
54. Ndi njira ziti zomwe udagwiritsapo ntchito?			54.
(***CHONGANI MAYANKHO ONSE – MAYANKHOP ANGAPO NDI OLOLEDWA.)***	***Yes***	***No***	Yes = 1, No=2
a. Mapilisi			a. _____
b. Lupu			b. _____
c. Jakisoni			c. _____
d. Thovu			d. _____
e. Makondomu			e. _____
f. Kutseka kwa amai			f. _____
g. Kutseka kwa abambo			g. _____
h. Njira yachilengedwe			h. _____
i. Kuthira umuna pambali			i. _____
j. Zitsamba			j. _____
k. Kudziletsa			k. _____
l. Kuyamwitsa mwana mwakathithi			l. _____
m. Njira zina (zitchuleni)***:*** _____			m. _____
55. Nanga panopa mukugwiritsa ntchito njira yolela iriyonse? 3. Inde 4. Ayi ⟶ **SKIP TO Q58 IF FEMALE, AND TO Q70 IF MALE**			55. _____

			PRECODE
56. Ndi njira iti yomwe ukugwiritsa ntchito panopa?			56.
(***CHONGANI MAYANKHO ONSE – MAYANKHO ANGAPO NDIOLOLEDWA.)***	***Yes***	***No***	Yes = 1, No=2
a. Mapilisi			a. _____
b. Lupu			b. _____
c. Jakisoni			c. _____
d. Thovu			d. _____
e. Makondomu			e. _____
f. Kutseka kwa amai			f. _____
g. Kutseka kwa abambo			g. _____
h. Njira yachilengedwe			h. _____
i. Kuthira umuna pambali			i. _____
j. Zitsamba			j. _____
k. Kudziletsa			k. _____
l. Kuyamwitsa mwana mwakathithi			l. _____
m. Njira zina (zitchuleni)***:*** _____			m. _____
57. Njira imeneyi mumakatenga kuti?			57.
(***CHONGANI MAYANKHO ONSE – MAYANKHO ANGAPO NDIOLOLEDWA)***	***Yes***	***No***	Yes = 1, No=2
m. Chipatala chachikulu chaboma			a. _____
n. Chipatala chaching'ono			b. _____
o. Oyendayenda a zaumoyo			c. _____
p. CBDA			d. _____
q. YCBDA			e. _____
r. BLM			f. _____
s. CHAM			g. _____
t. Chipatala cholipila			h. _____
u. Azamba			i. _____
v. Golosale/kogulitsa mankhwala			j. _____
w. Anzanga/achibale			k. _____
x. Kwina (kutchuleni)***:*** _____			l. _____

CHITHANDIZO CHA AMAI OYEMBEKEZERA NDI OMWE ABELEKA
(ATSIKANA OKHA NDIOMWE AYANKHE FUNSO 58 – 69)

	PRECODE
58. Unayamba wakhalapo ndi pakati? 3. Inde **4.** Ayi ⟶ **SKIP TO Q70**	58. _____
59. Wakhalapo ndi pakati kangati? _____ (**Lembani Nambala Yake)**	59. _____
60. Unali ndi zaka zingati panthawi yomwe unatenga mimba yoyamba? _____ (**LEMBANI NAMBALA YA ZAKA)**	60. _____
61. Kodi pakati/mimba yanu yomaliza munayamba sikelo ili ndi miyezi ingati? 5. Ndisanathe miyezi itatu 6. Pakati pa miyezi inayi ndi isanu ndi umodzi 7. Pakati pa miyezi isanu ndi iwiri ndi miyezi isanu ndi inayi 8. Sindinakafunefune chithandizo ***(pitani ku funso 63)***	61. _____
62. Ndikuti komwe udakayamba sikelo? a. Pa chipatala chachikulu cha boma b. Chipatala chaching'ono c. Chipatala cholipila d. TBA e. Kunyumba f. Kwina (kutchuleni) _____ **If currently pregnant skip to Q70**	62. _____
63. Nanga munaberekera kuti? a. Ku chipatala chachikulu cha boma b. Chipatala chaching'ono c. Chipatala cholipila d. TBA e. Kunyumba f. Kwina (kutchuleni***)*** _____	63. _____

	PRECODE
64. Amene anakuthandizani kuti mubereke ndani? a. Azamba b. Anamwino **c.** Ogwira ntchito kuchipatala **(PROBE)** d. Achibale e. Palibe f. Ena (atchuleni): _____	64. _____
65. Okuthandizaniyo anakusamala bwanji/motani? 4. Bwino kwambiri 5. Bwino 6. Sanandisamale bwino	65. _____
66. Kodi mutabereka munapitanso kukalandira chithandizo?? 3. Inde 4. Ayi ⟶ **SKIP TO Q68**	66. _____
67. Chithandizo chimenechi unachilandila kuti? a) Ku chipatala chachikulu cha boma b) Chipatala chaching'ono c) Chipatala cholipila d) TBA e) Kunyumba f) Kwina (kutchuleni*)* _____	67. _____
68. Pamene unali ndi mimba yomalizayi , udalangizidwapo za kulera (kusikelo/kapena pamene unabereka) 3. Inde 4. Ayi	68. _____
69. Panthawi yomwe unali ndi mimba yomalizayi abale ako anakusamalira bwanji? _____ _____ _____	69. _____

MATENDA OPATSIRANA POGONANA

			PRECODE
70. Kodi unayamba wamvapo za matenda opatsilana pogonana? 3. Inde 4. Ayi ⟶ **MALE GO TO Q82, FEMALE GO TO Q85**			70. _____
71. Nanga udamvera kuchokera kuti?			71.
(***Chongani mayankho onse – mayankho angapo ndiololedwa.)***	***Yes***	***No***	Yes = 1, No=2
n. Pawailesi			a. _____
o. Munyuzipepala			b. _____
p. Kwa nthumwi yazaumoyo			c. _____
q. Ku mzikiti			d. _____
r. Ku tchalitchi			e. _____
s. Ku sukulu			f. _____
t. Gulu la amai ndi abambo			g. _____
u. Gulu la achinyamata			h. _____
v. Anzanga			i. _____
w. Achibale			j. _____
x. Zokhomakhoma/mabuku/zolembalemba			k. _____
y. Palibe			l. _____
z. Kwina (kutchuleni***):*** _____			m. _____
72. Kodi ndi matenda ati opatsilana pogonana omwe umawadziwa?			72.
(***Chongani mayankho onse – mayankho ambiri ndiololedwa – yang'anani kwambiri zizindikiro zamatendawa***	***Yes***	***No***	Yes = 1, No=2
k. Chinzonono			a. _____
l. Chindoko			b. _____
m. Njelewere zakumaliseche			c. _____
n. Chancroid			d. _____
o. Trichomoniasis			e. _____
p. Mabomu			f. _____
q. Mauka			g. _____
r. Herpes symplex			h. _____
s. Ena (atchuleni) _____			i. _____
t. Ena (atchuleni) _____			j . _____
73. Pa miyezi khumi ndi iwiri yapitayi, kodi unatengako ena mwamatenda opatsilana pogonanawa? 3. Inde 4. Ayi ⟶ **IF MALE GO TO Q82, FEMALE GO TO Q85**			73. _____

			PRECODE
74. Ndi matenda opatsilana pogonana ati omwe unatenga?			74.
(***Chongani mayankho onse – mayankho ambiri ndiololedwa.)***	***Yes***	***No***	Yes = 1, No=2
a) Chinzonono			a. _____
b) Chindoko			b. _____
c) Njelewere zakumaliseche			c. _____
d) Chancroid			d. _____
e) Trichomoniasis			e. _____
f) Mabomu			f. _____
g) Mauka			g. _____
h) Herpes Symplex			h. _____
i) Ena (atchuleni) _____			g. _____
j) Ena (atchuleni) _____			h. _____
75. Nanga unalandila chithandizo? Inde Ayi ~~SKIP~~ **TO Q80**			75. _____
76. Nanga ndikuti komwe unakalandilako chithandizocho?			76.
(***Chongani mayankho onse – mayankho ambiri ndiololedwa.)***	***Yes***	***No***	Yes = 1, No=2
k. Chipatala chachikulu chaboma			a. _____
l. Chipatala chaching'ono			b. _____
m. Oyendayenda a zaumoyo			c. _____
n. Blm			d. _____
o. Chipatala cholipila			e. _____
p. Azamba			f. _____
q. Kugolosale/kogulisila mankhwala			g. _____
r. Anzanga/achibale			h. _____
s. Ndinazithandiza ndekha			i. _____
t. Kwina (kutchuleni***):*** _____			k. _____
77. Unathandizidwa bwanji pamene umakalandila mankhwala? 4. Bwino kwambiri 5. Bwino 6. Sanandithandize bwino			77. _____
78. Amene anakuthandizaniyo anakulangizani za mmene mungadzapewere matendawa mtsogolo muno? 3. Inde 4. Ayi ——————→**SKIP TO Q80**			78. _____

			PRECODE
79. Anakuuzani chiani?			79.
(***Chongani mayankho onse – mayankho ambiri ndiololedwa.)***	***Yes***	***No***	Yes = 1, No=2
g. Kudziletsa kugonana			a. _____
h. Kumagwiritsa ntchito makondomu			b. _____
i. Kupewa kugonana ndi anthu ambiri			c. _____
j. Zina_____***(zitchuleni)***			d. _____
k. Zina_____(*zitchuleni)*			e. _____ f. _____
l. Zina_____***(zitchuleni)***			
80. Pamene unali ndi matenda opatsilana pogonan kapena zina mwa zizindikiro zake, udawauza makolo ako? 3. Inde 4. Ayi			80. _____
81. Pamene unali ndi matenda opatsilana pogonan kapena zina mwa zizindikiro zake, udafotokozera chibwenzi/zibwenzi zako? 5. Inde 6. Ayi			81. _____

MAFUNSO OYAMBIRA PA 82– 84 NDI A AMUNA OKHA AMENE SANADWALEPO MATENDA OPATSIRANA POGONANA

	PRECODE
82. Amuna ena amamva kupweteka pokodza. Mmiyezi khumi ndi iwiri yapitayi wamvapo kupweteka kwa mtunduwu? 4. Inde 5. Ayi 6. Sindikukumbukira	82. _____
83. Amuna ena matuluka mafinya mchokodzela chawo. Mmiyezi khumi ndi iwiri yapitayi, zakuchitikirapo zoterezi? 4. Inde 5. Ayi 6. Sindikukumbukira	83. _____
84. Amuna ena amakhala ndi tizilonda/tinsungu kumaliseche awo osati chifukwa choti avulala ayi, pa miyezi khumi ndi iwiri \\ yapitayi, waonapo tinsungu timeneti kumaliseche ako? 1. Inde 2. Ayi 3. Sindikukumbukira	84. _____

FUNSANI FUNSO 85 MPAKA 88 KWA AKAZI OKHA AMENE SANADWALEPO MATENDA OPATSIRANA POGONANA

	PRECODE
85. Miyezi khumi ndi iwiri yapitayi wakhalapo ndi ukazi okudabwitsa? 1. Inde 2. Ayi **3.** Sindikukumbukira	85. _____
86. Pamiyezi khumi ndi iwiri yapitayi wamvako kuyabwa kumaso/kumaliseche ako? 1. Inde 2. Ayi 3. Sindikukumbukira	86. _____
87. Mmiyezi khumi ndi iwiri yapitayi wakhalapo ndi tinsungu kumaliseche/kumaso osati chifukwa cha kuvulala? 1. Inde 2. Ayi 3. Sindikukumbukira	87. _____
88. Pamiyezi khumi ndi iwiri yapitayi, wakhalapo ukumva kupweteka pachinena mophatikizana ndi kutentha thupi osati chifukwa cha kusamba ai? 1. Inde 2. Ayi 3. Sindikukumbukira	88. _____

FOR BOTH MALE AND FEMALE

			PRECODE
89. Kodi ungathe kunena njira zonse zimene munthu angatsate kuti asatenge matenda opatsila pogonana?			84.
(***Chongani mayankho onse – mayankho ambiri ndiololedwa.)***	***Yes***	***No***	Yes = 1, No=2
a. Kudziletsa chiwerewere			a. _____
b. Kugwiritsa ntchito makondomu			b. _____
c. Popewa kugonana ndi zibwenzi zambiri			c. _____
d. Posapanga mitala			d. _____
e. Pogwiritsa ntchito jakisoni kapena singano wophitsidwa kapena wosagwiritsidwa ntchito			e. _____
f. Njira zina (zitchuleni) _____			f. _____

Tsopano Ndafuna Ndikufunseniko Zambiri Zokhudzana Ndi Chithandizo Cha Uphungu Chopezeka Mdela Lanu

			PRECODE
90. Kodi udamvapo zadongosolo yopereka chithandizo cha zaumoyo wokhudzana ndi uchembere komamnso zogonana kwa achinyamata? Inde Ayi			90. _____
91. Kodi uli mu youth club? 1. Inde 2. Ayi **SKIP TO Q93**			91. _____
92. Tchulani dzina la youth club yanu? Dzina _____			92. _____
93. Kodi udamvapo ma youth resource centre? 1. Inde 2. Ayi **SKIP TO Q 101**			93. _____
94. Kodi udayamba wapitako ku youth resource centre mmiyezi isanu ndi umodzi yapitayi? Inde Ayi **SKIP TO Q101**			94. _____
95. Tchulani dzina la malowa? Dzina _____			95. _____
96. Udamva ndani zoti kuli malo oterewa?			96.
(***CHONGANI MAYANKHO ONSE – MAYANKHO ANGAPO NDIOLOLEDWA.)***	***Yes***	***No***	Yes = 1, No=2
a. Youth Zone Coordinators			a. _____
b. Pawailesi			b. _____
c. Peer Educator			c. _____
d. TV			d. _____
e. Newspaper			e. _____
f. chibale			f. _____
g. Anzanga			g. _____
h. Aphinzitsi			h. _____
i. Newsletter			i. _____
j. Zokhomakhoma			j. _____
k. Zolembalemba			k. _____
l. Akulu achipembezo			l. _____
m. YCBDA			m. _____
n. Open Day			n. _____
o. Chikwangwani chonena zamalowa			o. _____
p. Kwina (kutchuleni): _____			p. _____
q. Sindikudziwa/sindikukumbukira			q. _____

			PRECODE
97. Kodi cholinga chako chinali chotani pamene udapita komaliza ku malo amenewa?			97.
(***CHONGANI MAYANKHO ONSE – MAYANKHO ANGAPO NDIOLOLEDWA.)***	***Yes***	***No***	Yes = 1, No=2
a. Kukakumana ndi anzanga			a. _____
b. Kukachita zamasewero			b. _____
c. Kukamva uphungu wa uchembere wabwino			c. _____
d. Kukagawana uthenga wa uchembere wabwino			d. _____
e. Chifukwa china (chitchuleni***):*** _____			e. _____
f. Sindikudziwa/sindikukumbukira			f. _____
98. Kodi ungathe kudzapitakonso kumalowa? 1. Inde 2. Ayi **SKIP TO Q100** 98. Sindikudziwa **SKIP TO Q100**			98. _____
99. Nchifukwa chiyani ungadzapitenso kumalowa?			99.
(***CHONGANI MAYANKHO ONSE – MAYANKHO ANGAPO NDIOLOLEDWA.)***	***Yes***	***No***	Yes = 1, No=2
a. Kuli ogwira ntchito ansangala/othandiza			a. _____
b. Ndikomwe timakakambilana ndi alangizi aachinyamata			b. _____
c. Sikutali kwambiri			c. _____
d. Kunandisangalatsa			d. _____
e. Kukathandizika pa vuto lina lililonse lazaumoyo			e. _____
f. Chifukwa china (chitchuleni): _____ **SKIP TO 101**			f. _____
100.Nchifukwa chiyani siudzapitakonso?			100.
(***CHONGANI MAYANKHO ONSE – MAYANKHO ANGAPO NDIOLOLEDWA)***	***Yes***	***No***	Yes = 1, No=2
a. Nkofunika chilolezo chamakolo			a. _____
b. Mpofunika chilolezo cha wachikondi wanga			b. _____
c. Kuli ogwira ntchito opanda msangala/amwano			c. _____
d. Sasunga chinsinsi			d. _____
e. Ndimaopa kupitako			e. _____
f. Ndikutali			f. _____
g. Chifukwa china (chitchuleni): _____			g. _____
101. Kodi udamvapo za peer educator? 1. Inde 2. Ayi **SKIP TO Q104**			101. _____
			PRECODE

102. Kodi udayamba wakumana ndi peer educator pa miyezi isanu ndi itatu yathayi? 1. Inde 2. Ayi **SKIP TO Q104** 99. Sindikukumbukira **SKIP TO Q104**				102. _____
103. Ndikuti komwe unakumana ndi mlangizi wa achinyamata (peer educator) komaliza? 1. Kusukulu 2. Kuchipatala chaching'ono 3. Kumagulu aachinyamata 4. Kumalo komwe achinyamata amakalandila uphungu 5. Ku dela lathu 6. Kunsika 7. Malo ena (atchuleni): _____ 98. Sindikukumbukira				103. _____
104. Kodi udamvapo za alangizi achinyamata otengera kulela khomo ndi khomo (YCBDA)? 1. Inde 2. Ayi **SKIP TO Q108** 99. Sindikudziwa **SKIP TO Q108**				104. _____
105. Udakumanako ndi alanizi otengera kulela khomo ndi khomo? 1. Inde 2. Ayi **SKIP TO Q108** 99. Sindikudziwa **SKIP TO Q108**				105. _____
106. Udakumana naye kuti? 1. Kusuku 2. Kuchipatala chaching'ono 3. Ku magulu aachinyamata 4. Kumalo komwe achinyamata amapezako uphungu 5. Ku dela lathu 6. Ku nsika 7. Kumalo kwina (kutchuleni): _____ 99. Sindikudziwa				106. _____
107. Kodi mlangizi wachinyamata otengera kulela khomo ndi khomoyu anali:				107.
(*werengani mau onsewa)*:	Yes	No	DK	Yes =1, No =2, DK = 98
1. Ozindikira za ntchito yake				1. _____
2. Wansangala				2. _____
3. Amasangalasidwa nanu				3. _____
4. Oyenera pantchito yake				4. _____
5. Odziwa kulankhula				5. _____
6. Olemekeza anthu				6. _____
7. Waulemu				7. _____
8. Wosunga chinsinsi				8. _____
9. Wachilingamo ndi osabisa				9. _____
10. Omvetsetsa				10. _____
11. Otha kuthandiza				11. _____

				PRECODE
108. Udayamba wapitako kuchipatala kukafunsa chithandizo cha uchembere wabwino mmiyezi isanu ndi umodzi yapitayi? 1. Inde 2. Ayi. ***Pitani kumapeto a mafunsowa*** *If no, end interview*				108. _____
109. Ndi chipatala chiti chomwe mudapitako? _____ (dzina la chipatala)				109. _____
110. Unakachitako chiyani pa ulendo womalizawu?				110.
(*chongani mayankho onse, mayankho angapo ndiololedwa.)*		***Yes***	***No***	Yes = 1, No=2
a. Kukayezetsa mthupi				a. _____
b. Kukalandila chithandizo/mankhwala				b. _____
c. Kukafuna njira zolela				c. _____
d. Kukalandila uphungu wa HIV/AIDS				d. _____
e. Chifukwa china (chitchuleni): _____				e. _____
111. Udalankhulana/kuonana ndi ndani pamene udapitako komaliza?				111.
(*chongani mayankho onse, mayankho angapo ndiololedwa* ***- funsani kwambiri za mtundu wa chithandizo choperekedwa ndi amene anakumana nayeyo)***		***Yes***	***No***	Yes = 1, No=2
a. Dokotala				a. _____
b. Namwino				b. _____
c. Othandiza ntchito zaumoyo				c. _____
d. Mlangizi				d. _____
e. Ena (atchuleni***):*** _____				e. _____
f. Sindikudziwa/sindikukumbukira				f. _____
112. Amene anakuthandiza anali				112.
(*werengani mau onsewa)*	Yes	No	DK	Yes .=1, No =2, DK = 98
1) Ozindikira				1. _____
2) Wansangala				2. _____
3) Amasangalasidwa nanu				3. _____
4) Oyenera pantchito yake				4. _____
5) Odziwa kulankhula				5. _____
6) Olemekeza anthu				6. _____
7) Waulemu				7. _____
8) Wosunga chinsinsi				8. _____
9) Wachilingamo ndi osabisa				9. _____
10) Omvetsetsa				10. _____
11) Otha kuthandiza				11. _____
113. Kodi udzapitanso kuchipatalaku tsiku lina? 1. Inde 2. Ayi **SKIP TO Q115** 99. Sindikudziwa **SKIP TO END**				113. _____

	PRECODE

114. Nchifukwa chiyani ungadzabwererekonso?			114.
	Yes	***No***	Yes = 1, No=2
a. Kuli ogwira ntchito ansangala			a) ____
b. Umadikira nthawi yochepa			b) _____
c. Komwe achinyamata amakumanirako			c) _____
d. Komwe ndingacheze ndi alangizi			d) _____
e. Ndipafupi			e) _____
f. Kudandisangalatsa			f) _____
g. Kukathandizidwa pa vuto lililonse lazaumoyo			g) _____
h. Kukafuna chisamaliro ngati ndili oyembekezera			h) ____
i. Kukalandila chithandizo cha matenda opatsilana pogonana			i) _____
J. Chifukwa china (chitchuleni): _____			j) _____
IF ANSWERED Q114 SKIP TO END			

115. Ndichifukwa chiyani siukufuna kudzapitanso?			116.
(*chongani mayankho onse, mayankho angapo ndiololedwa.)*	***Yes***	***No***	Yes = 1, No=2
a) Pakufunika chilolezo chamakolo			a) _____
b) Pakufunika chilolezo chawachikondi			b) _____
c) Kuli ogwira ntchito olusa ndi amwano			c) _____
d) Ogwira ntchito salandira/safuna achinyamata			d) _____
e) Kulibe chinsinsi			e) _____
f) Ndimaopa kupitako			f) _____
g) Umadikilira nthawi yaitali			g) _____
h) Ndikodula mtengo			h) _____
i) Sapereka mankhwala			i) ____
j) Ndimakonda kupita kwa asing'anga			j) _____
k) Ndilibe mavuto okhuzana ndi zaumoyo			k) _____
l) Ndikutali			l) _____
m) Ndimakonda chipatala china			m) _____
n) Chifukwa china (chitchuleni)			n) _____
o) Other (specify): _____			o) _____

ATHOKOZENI ANTENGA MBALI KAMBA KA NTHAWI YAWO NDI KUYESETSA KWAWO

Annex 16: **Health Facility Service Utilisation Form**

ADOLESCENT FRIENDLY REPRODUCTIVE HEALTH SERVICES MONTHLY RETURNS

HEALTH UNIT…… MONTH……., Year……

AGE GROUP	**SERVICES PROVIDED**												
	FAMILY PLANNING		SEXUALLY TRANSMITTED INFECTIONS		HIV/AIDS COUNSELING & TESTING		GENERAL COUNSELING		ANC	DELIVERY	PNC	OPD CLIENTS	
	NEW	**REVISIT**	**M**	**F**	**M**	**F**	**M**	**F**				**M**	**F**
10 – 15 Years													
16 – 19 Years													
Total adolescents													
Total clients all ages in facility (incl. adolescents)													
Percentage of adolescents among all clients													
Number of condoms issued from store during the month			**Name of provider: ……**										

For each month, obtain the information on Family Planning, STI, HIV/AIDS counselling, general counselling from the adolescent care registers, the information on ANC and PNC visits from the ANC register, information on delivery from the maternity register and information on general clients from the OPD register.

Annex 17A: **FGD Question Guide for Unmarried Adolescents**

Location: *YFRHS/Non-YFRH* Date: _____

Introduction to FGD Sessions

We would like to thank you all for coming today. My name is ____. My colleague is _____. We are from _____. We are conducting a study on Youth friendly reproductive health services among unmarried adolescents. Some of the topics we are going to discuss concern sexual relationships between male and female adolescents, pregnancy, STIs including HIV/AIDS. We are particularly interested in what factors influence unmarried adolescents to use or not use SRH services. We are also interested to see what you feel about YFRHS as a measure for promoting and facilitating adoption of prevention strategies SRH problems. We feel by talking to people like you we can best find out about practices, opinions and feelings about these issues in order to help SRH interventions that would promote safer sexual behaviours among unmarried adolescents.

There are no wrong or right answers. We are interested in your views, so please feel comfortable to say what you honestly feel. I have a list of topics/questions I would like us to talk about but feel free to bring up any other issues you feel are relevant.

During the discussion, _____ will be taking notes to keep track of what has been covered, and to remind me if I forget to ask certain things. We will also be recording the discussions on tape so that _____ has not to take every word down on the paper. The tapes and written material will be kept safe and not shared outside the research team. After writing our report, all the tapes and written notes will be destroyed, so no one will know who said what.

Regarding the language, we want you to feel comfortable throughout the talk, so please just use the language that you use when chatting with friends. Finally, please try to let everyone have a turn at saying something, since all your views are important, and please try to keep the talk within the group. The discussion is confidential. Are there any questions?

Ice-breaker
Ask each participant to introduce themselves (first names only) and what they do.

1. How do young people of your age find out about relationships, sex, STI and HIV/AIDS?
2. What roles do schools, communities, families and religious institutions play in shaping unmarried adolescents' sexual and reproductive health behaviour?
3. What is the extent of sexual activity among unmarried adolescents in this community?
4. How would you describe the prevalence of STIs, HIV/AIDS and early pregnancies among unmarried adolescents in your society? What factors influence unmarried adolescents to engage in unsafe sexual and reproductive practices that could lead to SRH problems?
5. Do young people discuss issues of sexuality and reproduction? What discussion do young people have about sex, relationships, contraception, STI and HIV/AIDS?
6. What roles do cultural/social norms play in shaping sexual behaviour in your community? (Probe about gender, stigma, norms and traditions)
7. What measures are used to prevent STIs, HIV/AIDS and early pregnancies in your society?
8. What measures do unmarried adolescents use to prevent STIs, HIV/AIDS and early pregnancies in your society?

9. What role does the government/political system play in promoting SRH for the youth?
10. What do you know about YFRH services? Who can access them?
11. What impact has the availability of YFRH services had on utilisation of SRH by unmarried adolescents?
12. What factors have led to utilisation or reduced utilisation of YFRH services by unmarried adolescents?
13. How would you describe the quality of care in YFRH facility?
14. How would you like the quality of care at a YFRH facility be?
15. What recommendations would you make towards making YFRH programmes in order to attract more unmarried adolescents to use the services?

Annex 17B: **Mafunso okambirana pagulu la achinyamata**

Dzina la ofunsa_____ **Dzina la Oonerera :**_____
Malo YFRH/Non-YFRH **Mudzi**_____
Date_____ **Tsiku**:_____

Mawu otsogolera pa zokambirana zathu

Tikufuna tikuthokozeni chifukwa cha kubwera kwanu lero. Ine dzina langa ndi _____Nzangayu ndi _____. Tachokera ku _____. Tikupanga kafukufuku. Wokhudza achinyamata pogwiruitsa ntchito zipatalazomwe zimapereka mpata kwa a chinyamata kuti alandire chithandizo choyenera,moyenera.Chidwi chathu chiri pa achinyamata omwe sanakwatiew/re.

Mitu ina imene tikambirane ikhudza ubwenzi omwe umakhalapo pakati pa anyamata ndi asungwana ,matenda opatsirana`pogonana, HIV/Edzi komanso vuto la kutenga pakati mosakonzekera. Chidwi chathu makamaka chiri pa zifukwa zomwe zimapangitsa kapena kulepheretsaachinysmata kulandira chithandizo pa uchembere wawo.

Tilinso ndi chidwi chofuna kudziwa zimene inu mukuganiza pa chisamaliro chomwe chimaperedwa ku chipatala kwa achinyamata ndi cholinga chofuna kulimbikitsa achinyamatawo kupewa mavuto omwe amakumana nawo mmoyo wawo.

Tikuona kuti pokambirana ndi anthu monga inu tikhoza kudziwa machitachita, maganizo ndi mene mumamvera nkhani zimenezi kotro kuti zizathandiza kukhazikitsa ntchito zolimbikitsa moyo wabwino kwa achinyamata osakwatiwa/ra.

Mkukambirana kwathu palibe mayankho olakwikazomwe zomwe tizikambirana ndi zofunika zokhazokha. Choncho, tikukupemphani kuti mukhale omasuka potenga nawo mbali muzokambiranazi. Ndiri ndi ndandanda wa mafunso omwe tizikambirana.

Pamene tikukambirana, _____ azilemba fundo zomwe tikukambirana pofuna kuonetsetsa kuti fundo zonse zakhudzidwa. Komanso izi zithandiza kutikumbutsa ngati taiwarira mafunso kapena mfundo zina. Tizijambulanso zokambirana zonse pawailesi. Zolembazo pamodzi ndi zojambulazo zizasungidwa mwachinsinsi ndipo zidzagwiritsidwa ntchito yokhayo ya kafukufukuyi.

Pamene tikukambirana, tikukupemphani kuti tizigwiritsa ntchito chiyankhulo chomwe timagwiritsa ntchito tsiku ndi tsiku pamene tikucheza ndi azathu. Tiyeni tiyetsetse kupatsana mwayi kuti wina aliyense azipeza mpata woti ayankhulepo pa zokambiranazi. Ngati pali mafunso pa kafukufukuyi, khalani omasuka kufunsa.

Poyambira

Poyamba funsani munthu aliyense akutenga nao mbali muzokambiranazi kuti awauze amzake dzina lake (loyamba lokha kapena lomwe amagwiritsa ntchito pocheza) komanso anene zomwe iye amachita akakhale kwao. Izi cholinga chake nchoti anthuwo akhale omasukirana muzikambirana zao.

1. Kodi achinyamata amsinkhu wanuwu amaphunzira kuti zinthu zokhudzana ndi maubwenzi, kugonana, matenda opatsirana pogonana, HIV/Edzi komanso zokhuzana ndi kutenga pakati?
2. Kodi masukulu, anthu a midzi, makolo/mabanja ndi amipingo amachitapo chiyani powongolera achinyamata osakwatiwa pa moyo wao wokhudzana ndi zogonana modziteteza komanso uchembere wabwino?
3. Kodi mdera mwathu muno, nkhani yogonana pakati pa achinyamata osakwatiwa ndi yaikulu bwanji?
4. Mungalongosole bwanji mavuto a matenda opatsirana pogonana, HIV/Edzi komanso pakati potenga usanakonzekere pakati pa achinyamata osakwatira/wa mdera mwathu muno? Nanga ndi zifukwa ziti zimene zimawapangitsa achinyamatawa kuti azichita khalidwe lomwe lingawapezetse mavuto ngati amenewa?
5. Kodi achinyamata osakwatira/wa amakambirana nkhani yokhudzana ndi kugonana komanso uchembere? Amakambirana zotani zokhudzana ndi kugonana, maubwenzi, kupewa kutenga pakati, matenda opatsirana pogonana ndi HIV/Edzi.
6. Kodi miyambo ya mdera lino imatengatengapo mbali yotani powongolera khalidwe la achinyamata osakwatira/wa lokhudzana ndi zogonana ndi uchembere? (Funsani za zoyenera kuchita amuna ndi akazi, kumpats munthu maina ena chifukwa cha zomwe akuchita, miyambo)
7. Ndi njira ziti zomwe anthu akuno amagwiritsa ntcito popewa matenda opatsirana pogonana, HIV/Edzi, komanso kupewa kutenga mimba mdera lino?
8. Nanga achinyamata osakwatra/wa ngati inuyo mumagwiritsa ntchito njira ziti pofuna kuzitetedza nokha kumatenda opatsirana pogonana, HIV/Edzi, komanso kupewa kutenga mimba musanakonzekere?
9. Kodi inuyo mukuona kuti a boma kapena a ndale akuchitapo chiyani pokweza moyo wa achinyamata osakwatira/wa pankhani yogonana ndi uchembere?
10. Kodi munamvapo zotani zokhudzana ndi uchembere wabwino ndi ulangizi wa kugonana modziteteza wa achinyamata? Ndi ndani omwe angagwiritse ntchito zithandizo zimenezi?
11. Ngati zithandizo za uchembere wabwino ndi ulangizi wogonana modziteteza wa achinyamata kuno uliko, mukuona kuti wathandizapo bwanji pokopa achinyamata osakwatira/wa kuti azigwiritsa ntchito zithandizo zopewera mavuto a uchembere ndi matenda opatsirana pogonana?
12. Ndi zinthu ziti zomwe zikuwapangitsa achinyamata osakwatira/wa kuti azigwiritse kapena asamagwiritse ntchito zithandizo zomwe zingateteze iwo ku mavuto a uchembere ndi matenda opatsirana pogonana?
13. Munganene zotani pa chisamaliro chomwe achinyamata amalandira ku zipatala akapita kukafuna chithandizo chokhuzana ndi uchembere?
14. Kodi inuyo mukadakonda kuti chisamaliro chizikhala chotani mukapita ku chipatala kukafuna chithandizo chokhuzana ndi uchemebere wabwino?
15. Mukuganiza kuti pangachitidwe chiyani kuti dongosolo la uchembere wabwino wa achinyamata uthe kukopa aachinyamata osakwatira/wa ambiri kuti athe kupita kukalandira chithandizo chozitetedzera kumatenda opatsirana pogonana, HIV/Edzi komanso kupewa kutenga pakati asanakonzekere?

Annex 18: **Questions for Theoretical Sampling**

1. My results showed that girls are told some things which boys are not taught during initiation ceremony. Similarly, boys are told different things related to sexual behaviours which girls are not taught. What impact does this teaching have on adolescent sexual practice? Does that affect the way boys and girls relate to each other

sexually?

2. Recently there was a story in the local newspaper that some fathers are having sex with their daughters in this area, what influences such behaviours?
3. There have been stories in the local media that some fathers are having sex with their daughters, as the police/judiciary, what do you do about it? Is there anything you are doing to control such behaviours? What are they if any?
4. Some people are saying that you arrange new initiates to have sexual intercourse soon after initiation, why is that important?
5. You are a Christian but at the same time a health provider serving young unmarried people. How do these two roles fit or affect each other? Do you have time to discuss with your children about SRH? What do you discuss if any?
6. Your mother is a YFRHS provider, how does that affect you life in your home? What does your mother do as regards to SRH counseling? What influences her to do that?
7. How does stigma influence adolescents not to use SRH services?
8. There are norms in the society that promote premarital sexual activity as well as norms that prohibit such sex. How does that affect adolescent sexual behaviours?

Annex 19: Religious leaders and Defilement

National Section

Printable View | All Olivia's Articles | Send to friends | Send note to Writer

Girl, 5, implicates sheikh in defilement

by OLIVIA KUMWENDA (2/28/2008)

photograph by

Police in Mangochi have arrested a sheikh from Simon Village, T/A Chowe in the district for allegedly defiling a five-year-old girl.

Mangochi Police spokesperson Rodrick Maida said yesterday the suspect, Sheikh Jawadu Mbiya, runs Marshar Ailah Islamic and Madrassah Nursery which has 24 children, 19 of whom are girls.

"It is reported that when teaching, the sheikh would carry one of the pupils on his lap and Wednesday [Tuesday] he took the victim to his office and lay her on the table where he defiled her," said the police spokesperson.

He said it is the victim's grandmother who saw the sheikh and the girl coming out of the office as she (the grandmother) came to collect the girl.

Said Maida: "The grandmother was suspicious and asked the girl what she was doing in the sheikh's office when they got home. The girl revealed that she was defiled."

She was later taken to hospital where the defilement medical tests confirmed and the matter was reported to Police.

According to Maida, Sheikh Mbiya — whom we could not talk to for his side of the story — allegedly admitted that he defiled the girl and will soon appear before court to answer a defilement charge.

In another development, police in the same district are keeping in custody 20-year-old Mussa Shukurrani for abducting a 13-year-old girl and keeping her under his custody for a week.

Maida said Shukurrani took the girl to his home on February 8 where he kept her up to February 15.

"The girl said while at his place he would make her take some drug which would put her to sleep. But she does not know what he was doing when she was asleep," said Maida.

A medical check, however, did not indicate the girl might have been defiled, he said.

Annex 20: **Questionnaire Monitoring Sheet**

Cluster ID_____ Cluster Name _____ Zone _____

**** Remember to indicate dates against each signature**

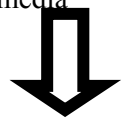
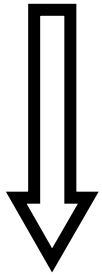
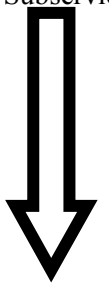
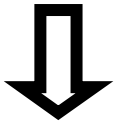
	1	2	3	4	5	6	7	8	9	10	11
Ques #	**Questionnaire ID**	**Respondent Household ID**	**Brought in by**	**Edited by**	**Callback Y/N? If No, go to 9**	**Handed back to**	**Brought in by**	**Edited by**	**First entry by**	**Second entry by**	**Archived by**
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											

Annex 21: **Data Entry Log Sheet**
Name Of Clerk: _____

Date	**Cluster(Intervention/Nin-intervention)**	**Questionnaires entered**

Annex 22: Thematic Analysis Table - Identified Common Themes and Categories

Level of Coding	**Common Themes 1**	**Common Themes 2**	**Common Themes 3**	**Common Themes 4**	**Common Themes 5**
Open Coding	-Pregnancy-badge f fertility (man and woman) and womanhood -Pregnancy –sign of immorality, whore -STI –badge of masculinity -STI –sign of immorality, whore -Sex- transition passage rite -Sex-acceptable in some traditions: cultural cleansing, 'chitomero', 'chisuweni' -Arranged sex following initiation -Sex- deviant and immoral behaviour -Abstinence- norm among unmarried people -Multiple sexual partner-sign of manliness -Multiple sexual partner-immorality -Sex education not acceptable	-Male have sexual control power -Females are to be subservient to be 'good woman' -Sex a sign of masculinity -Pregnancy a sign of womanhood -Pregnancy increases woman's social status Pregnancy proves male's virility -STI, a sign of manliness -SRH use – males' decisions -Females not to make any decision regarding SRH use	-ABC as approach to ARH promotion –Health facility -AAA as approach to ARH promotion – traditional -SRH education a taboo -SRH education – a SRH right -Traditional health care used for treatment of SRH problems -Modern health as effective for SRH promotion -Early pregnancy- God's gift -Early pregnancy- a health risk -HIV- preordained by God -HIV – a consequence of sinful behaviour -HIV- is preventable by using SRH services -STI: badge of masculinity -STI: health risk -STI: use traditional cure -Death: preordained, can't be prevented -Death: preventable by using SRH services	-Girls have sex with older men for money and other gifts or good test results in schools -Girls value sex trade over SRH problems -Unprotected sex earn more money than protected sex - Sex trade for livelihood and other life necessities -Business women have sex with boys as a bait to induce the boys to sell their fish at cheap price -Boys acquire high status among peers due to their association with business women- considered of high status	-Sexually active adolescents seen as whores and immoral - Boys not involved in sex considered 'not real men' -Pregnancy as a consequence of immorality -Lack of pregnancy as sign of impotency -STI as sign of manliness -STI as a sign of being unfaithful and immoral behaviours -Use of SRH: a sign of immorality among unmarried adolescents

	-Sex education –done in initiation camp, schools, mass media 		-SRH service use: not acceptable among unmarried people SRH service use- the way to prevent SRH problems 		
Axial Coding	Other norms promote sex Other norms prohibit sex 	Male Power Control Female Subservience 	-Sexuality has cultural and social meanings and can be prevented using traditional means -SRH problems can be prevented by using modern health services 	-Economic power increase male's power -Economic gain and dependence compromise women's autonomy over SRH Homosociality increase boys' vulnerability 	Religious communities view SRH problems differently from the traditional communities 
Selective Coding	Ambiguous Normative Culture	Structural Gender Asymmetry	Tensions between traditional and modern approaches to ARH promotion	Politics of Economic Change and Transactional Sex Livelihood takes precedence over SRH promotion	Ambiguous stigmatisation culture on sexuality and SRH issues within societies

Annex 23: **RESEARCH TEAM**

Principal Investigator: Jimmy Gama

Research Assistants

Survey Research Assistants		***Others***
Household Listing Enumerators Edwin Devete Rajab Saidi Clement Howa Omar Chingomanje Christopher Ndaona Samson Mlenga Alidi Issa Bashira Ishmael A. Mdala Matthews Mbonera Banda Foster Kamtrwera Alex W. Amadu Victor V. Nyungwa Christopher Muhajiri Mark Lemison Dennis Grace Mawenda Bonkey Namkwenya William Msusa Bamusi D Chiganga Victor Kamuzu Emmanuel Chidaya Banda Alexious N Chiromo Isaac Salimu Jack Gama Twailo Msusa Chimwala ***Survey Data Collectors*** Phillip Nyalugwe Violet Gondwe Gladys Chimombo Chiyembekezo Kasitomu Ireen Kachingwe Moses Magundani Lenita Jamu Limbani Alumanza Vonono Makuta Rose Mauluka Emanuel Banda Ethel Kankhomba Vera Kanyika Raphael Josofati Enock Chiphwanya Evelino Chitseko Leonard Shabani Madalitso Chimeta	Lemisoni Kunkeyani Ben Namagowa Noel Hara Kondwani Ndoya Emily Pondeponde Peter Kachikuni Heck Chipwatali Franklin Malisawa Charles Cecil Kasito Francis Khonyongwa Laston Mbewe Maxwell Pangani Martha Bunya Overton Jamali Clement Howa Asnet Chikwete Golden Makanjira Mande Mcheka Christina Nkolokosa Evance Chingwalu Geofrey Banda Chisomo Ndengu ***Survey <u>Field Supervisors</u>*** Maxwell Pangani Francis Khonyongwa Charles Cecil Kasito Martha Bunya Laston Mbewe Franklin Malisawa ***<u>Data Entry Clerks</u>*** Loyce Mchakama Yamikani Henderson Zuzo Zakaliya Gladys Maduka Doreen Banda	<u>In- depth Interviewers (Initiation counsellors)</u> *Interviewers for Male Counselors* Faki Hassan Adam Alide *Interviewers for Female Counselors* Faith Kachala Sofi Bakali <u>Health Services Utilisation Data Collectors</u> Enock Phale Maxwell Pangani Simeon E Malewa Francis Khonyongwa <u>Trainers of data collectors - Survey</u> Maggie Kambalame Francis Khonyongwa Maxwell Pangani Jimmy Gama Phillip Ngombaela <u>Trainers of Data Entry Clerks</u> Allison Zakaliya Jimmy Gama